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SELECT COMMITTEE ON HEALTH

CHAIRMAN: Callahan, R. V. (Brampton L)
Andrewes, P. W. (Lincoln PC)
Baetz, R. C. (Ottawa West PC)
Cooke, D. S. (Windsor-Riverside NDP)
Jonnston, R. F. (Scarborough West NDP)
Poirier, J. (Prescott-Russell L)
Polsinelli, C. (Yorkview L)
Reycraft, D. R. (Middlesex L)
Sargent, E. C. (Grey-Bruce L)
Stephenson, B. M. (York Mills PC)
Turner, J. M. (Peterborough PC)

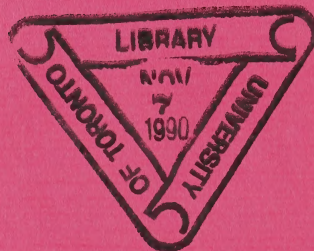
Substitution:

Mitchell, R. C. (Carleton PC) for Miss Stephenson

Clerk: Deller, D.

Staff:

Gardner, Dr. R. J. L., Assistant Chief, Legislative Research Service



LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON HEALTH

Wednesday, July 16, 1986

The committee met at 2:16 p.m. in committee room 1.

ORGANIZATION

Mr. Chairman: Welcome to the select committee on health. Do we have any nominations for vice-chairman?

Mr. Polsinelli: I nominate Mr. Poirier.

Mr. Chairman: Are there any further nominations? All in favour?
Agreed.

Mr. Polsinelli moves that unless otherwise ordered, a transcript of all committee hearings be made.

Motion agreed to.

Mr. Chairman: Mr. Poirier moves that the following members compose a subcommittee on agenda and procedure and that the said subcommittee meet from time to time at the call of the chairman to consider and report to the committee on the business of the committee; that substitution be permitted on the subcommittee and that the presence of all members of the subcommittee is necessary to constitute a meeting: The member for Windsor-Riverside (Mr. D. S. Cooke) from the New Democratic Party, the member for Lincoln (Mr. Andrewes) from the Progressive Conservative Party, and the member for Middlesex (Mr. Reycraft) from the Liberal Party.

Motion agreed to.

Mr. Chairman: The next item is the budget and the clerk will pass around copies of our rather simple, bare-bones budget. I will give members an opportunity to review the budget briefly.

Have you had an opportunity to look at the budget? Are there any questions on it?

Mr. Baetz: For what period of time is this?

Mr. D. S. Cooke: I think it would be more appropriate if the committee, before deciding on the budget, decided what we are going to do this summer, because it will have an impact on the budget.

Mr. Chairman: That makes sense. Let us move that down.

Mr. D. S. Cooke: May I make a suggestion if we are going to move on to what we are going to do this summer?

Mr. Chairman: Please do.

Mr. D. S. Cooke: Mr. Andrewes, the chairman and I met last week and I think we all came to the conclusion that because the terms of reference were

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passed on the last day the House was sitting, and we had not looked at the issue of staffing of the committee or tried to narrow what the committee was going to do, we were all a little bit all over the map.

If we are going to look seriously at this issue, it seems to me what we should be looking at is hiring good staff for the committee, staff that would work with the clerk of the committee and legislative library research. I have a suggestion for staff but we can get into that later. It would seem appropriate to me, if the steering committee met with the proposed staff on the first day after the Civic Holiday, then the committee could meet with staff that week as well and then come to a final determination as to who staff would be, give them some direction and have a further meeting with staff in the last week of August.

The terms of reference call for an interim report in six months but the interim report was envisioned to have data on the extent of commercialization of health and social services in the province and an indication of what the committee wants to do with that information and how we are going to come to recommending policy to the Legislature. If we had those two weeks, in the last week of August we could give staff some direction as to what we want them to do in the fall, collecting all the data, and what we want to do next winter during the winter break, when we would then have our extensive public deliberations and start preparing a final report after those deliberations.

It may be that we cannot do a final report in 12 months as called for by the terms of reference, and if we cannot, we can always ask for an extension. If we sit for four weeks in August just for the sake of sitting for four weeks and have not had direction and some assistance from staff at narrowing what we are going to deliberate upon, then we are going to be walking all over the place and we will not have done anything but meet for four weeks and probably wasted two or three of those weeks.

So that people know what staff I am referring to, I talked to the Social Planning Council of Metropolitan Toronto and a number of other groups involved in the health care field and everyone seems to indicate that the two people we should try to get are Greg Stoddart and Roberta Labelle from McMaster University who have worked extensively in this field and who were referred to extensively during the Bill 94 hearings. Mr. Stoddart and Ms. Labelle prepared the federal report, Privatization in the Canadian Health Care System, published in October 1985. Mr. Stoddart staffed a select committee of the Legislature on health care financing--was it in 1978 or 1979?

Mr. Taylor: It was 1974 or 1975.

Mr. D. S. Cooke: I thought it was after the budget that brought in the big increase in Ontario health insurance plan rates, which was after I was elected. However, it was in the 1970s. He has had experience with a select committee and experience in this field. I think that would be the appropriate direction to go and they are interested in working with the committee. I am the only person who has talked to them and obviously I had no authorization to do anything other than to tell them we were looking for staff. They would like to meet with the steering committee and the whole committee before they commit themselves to staffing the select committee.

Mr. Turner: I think somebody at the University of Toronto was involved in that committee report as well. I cannot think of his name offhand.

Mr. Andrewes: I tend to agree with my colleague the member for

Windsor-Riverside that we would be wasting our own time and the time of many people by sitting in August without giving some thought and some direction and without having some overall plan. At this stage, which is mid-July, it does not appear to me that we are going to be able to prepare ourselves for the kind of effective hearing we want to have.

I concur with the idea of the steering committee meeting with potential staff support early in August and that we make some kind of presentation to the committee as a whole following that. But it would be my view that this committee should consider at least hearing this fall--possibly late August or September--from the ministries involved in order that we could have an overview and round ourselves out in terms of the jurisdiction of those ministries, the legislation that comes under their jurisdiction and the services that are delivered under that legislation.

That could be done without a lot of staff planning and involvement. It would mean the committee at this stage or at some stage, say early in August, would need to give those ministries some direction. It would be helpful to get that kind of homework out of the way before we get into further hearings, calling witnesses and the usual type of thing a committee would embark on.

Mr. Chairman: I should advise the committee that the Ministry of Community and Social Services and the Ministry of Health have been advised of this. The Ministry of Health is available. The Ministry of Community and Social Services may be available a bit later in the period. Is that correct?

Clerk of the Committee: I should explain that. Both ministries have been advised of what the terms of reference of the committee are and that the committee will want to have a briefing from them. I suggested some time in August, either the first or second week, but I said that might change today.

Mr. Chairman: Are there any further comments with reference to what Mr. Andrewes and Mr. Cooke have said? We have two similar but slightly different variations.

Mr. D. S. Cooke: I do not disagree if in the last week of August, in addition to meeting with staff, we want to have initial briefings from the ministries. That makes sense and would help us put things in perspective.

Mr. Sargent: This may be redundant--I probably missed something--but who wrote the terms of reference here?

Mr. Chairman: It was a combined effort. Actually, I have to give a lot of credit to Mr. Cooke; I revamped it, but I note that none of my revamping came out in the wash. It was minor revamping, you might say.

Mr. Sargent: My main question is why?

Mr. Turner: Why what?

Mr. Sargent: What are we here for?

Mr. Chairman: That is the thrust of Mr. Cooke's and Mr. Andrewes's comments, that we should try to determine that in advance so we are not running off in five different directions.

Mr. D. S. Cooke: We know why we are here. It is just a matter of trying to make sure we get to the end without wasting a lot of time in between.

Mr. Andrewes: To help Mr. Sargent--

Mr. Sargent: What is our right to investigate the for-profit sector of health? That is none of our business.

Mr. Chairman: No. What we are doing is we are looking at the question of how we currently provide the service--anybody stop me if I am wrong--how it might be provided perhaps in a commercialized way and, I suppose, the benefits from both a cost standpoint and an efficiency standpoint should we decide that is the route to go.

Mr. D. S. Cooke: You put the emphasis on the other side--

Mr. Chairman: I realize that--or vice versa.

Mr. D. S. Cooke: However, the terms of reference are passed.

Mr. Andrewes: It is all in the accord, Eddie.

2:30 p.m.

Mr. Mitchell: I happen to think the directions suggested by both are good. The suggestion of Mr. Andrewes is very important because we need to know what directions both ministries are already planning to go. That planning was done in advance of this motion.

It is also important that the steering committee meet with consultants who might be offering their services to this committee. I do not think any of us on this committee, unless we first met with everyone who wanted to do it, would have any idea of their qualifications and so on. Perhaps there should be an initial screening by the steering committee, and then those it recommends or who made a short list would come before this committee to be considered for that role.

Obviously, I am speaking as a substitute, but I think meeting with the Ministry of Health and the Ministry of Community and Social Services in late August is the proper way to go. Some direction has already been started in Health. One needs only look at the hospital in Hawkesbury that is currently operated by private business. It is doing well, but those are the things this committee wants to know.

Mr. Chairman: Are there any further comments? Perhaps we could distil this by first agreeing or disagreeing with what was said by Mr. Andrewes and Mr. Cooke about how we go about doing this. Is that the concurrence of the rest of the committee members?

Interjection.

Mr. Chairman: All right. Perhaps we could distil that a little further. We currently have four weeks allocated to sit, with a fifth week, possibly, in September. I gather from what Mr. Andrewes has said that we do not need all of August. Perhaps we could get a consensus on what Mr. Cooke said about the subcommittee meeting the day after the Civic Holiday.

Mr. D. S. Cooke: If the committee wants to meet in September, we can try that, but the whips have made a schedule. It is not a particular problem for my caucus, but it is a major problem for the Liberal caucus. They do not have a lot of members, and there are a lot of committees already meeting in September.

If we can do it, I think we should meet the first and last weeks of August. The only question would be whether the last week of August gives us enough time to get the briefings from the ministries as well as meet with our staff. If we wanted to do the briefings in the last week of August and look at a September meeting with staff, we might be able to get away with that.

Mr. Chairman: Are you moving that the entire committee meet the first week of August? You first said the steering committee would meet with the consultants the day after the Civic Holiday. It is a short week.

Mr. D. S. Cooke: I suggest the clerk contact soon whomever we decide and see whether they are available in that first week of August to meet with the steering committee one day and the full committee the day after. In addition to the steering committee, I assume the full committee wants to meet with the staff before it confirms the recommendation from the steering committee. I do not know. I have never been on a select committee that has been staffed.

Mr. Chairman: Are there any comments on that?

Mr. Turner: It is a good idea and I would like the opportunity to meet with staff. It is important. However, in that first week, I am not going to be able to be here.

Mr. Chairman: I am sure we will receive a quality substitute for you.

Mr. Turner: No doubt.

Mr. Reycraft: I am not clear on what Mr. Cooke thinks we would accomplish in the first week of August if we had this meeting with staff and the whole committee. What would be the purpose?

Mr. D. S. Cooke: We have to hire staff and we cannot do that until the committee meets formally to do that. Because Mr. Andrewes is not available until the first week of August, if we decide to go with Stoddart and Labelle, the steering committee cannot interview them until then. They have not agreed to do this; they have said they are interested. I thought we would want to interview them.

Mr. Mitchell: I have a question on something Mr. Cooke said. Did I miss something? Are you recommending Stoddart and Labelle as the only ones the steering committee would meet with?

Mr. Chairman: You should have a list in front of you.

Mr. Mitchell: I have the list; it is the way it was put.

Mr. Chairman: We will get to that issue shortly. He is just suggesting the way we go about it at the moment.

Mr. Mitchell: My position is that the steering committee would meet with anyone who was to be considered for the possible staffing, do the initial screening and make up a short list of two or three, and then the whole committee will meet with them.

Mr. Chairman: Perhaps we should address the question of the time frame that was suggested by Mr. Cooke, or perhaps we should do it in reverse.

Perhaps we should discuss what you have raised, Mr. Mitchell, namely, the question of how we go about speaking to these consultants and creating a list to be looked at by the entire committee the next day, the day after or whatever.

Mr. Baetz: It is very important for the committee as a whole and the subcommittee to take a very close look at possible consultants, because the kind of exercise we will be engaged in lends itself very readily to biases. It is going to be very important that before making any decisions on the hiring of consultants, all of us know what biases they may or may not have. Their task is going to be largely data collection, analysis and so on, but it is essential that we know who they are so we can weigh their data. I know these were only initial proposals, but I hope the subcommittee will have a much larger list than two possible names to look at and will also take a look at their background.

Mr. D. S. Cooke: One of them--

Mr. Chairman: Excuse me, do you have the same list we have? I have four of them on it.

Mr. Baetz: I have only Greg Stoddart on mine.

Mr. Chairman: I have four possible contacts.

Mr. Andrewes: I know what he is going to say.

Mr. D. S. Cooke: A card-carrying Tory.

Mr. Baetz: Exactly.

Mr. Andrewes: Even Tories are known to have certain biases.

Mr. D. S. Cooke: I was trying to show how balanced I was.

Mr. Baetz: I am not worrying about Mr. Cooke having talked with two people, but in the overall exercise of determining who the staff should be, we should keep in mind some kind of balance in terms of their possible biases.

Mr. D. S. Cooke: As a social worker, you understand we are never going to find anyone in this field who does not have some idea of what he would like to see.

Mr. Baetz: This is precisely why I am making the point. You and I understand each other.

Mr. D. S. Cooke: Knowing the personalities on this committee, they will never get away with it.

Mr. Turner: I do not know whether it is the proper time to do this, but associated with Greg Stoddart on the original select committee on health care financing and costs, there was a health economist by the name of Bob Evans, who was very impressive and did a great deal of work. Do you know him?

Mr. Andrewes: I do not know him.

Mr. D. S. Cooke: I have to talk to these people again today. I am sure Stoddart would--

Mr. Chairman: I wonder if we are not going around the issue here. I have found in the past that the steering committee speaks to them, and then they come back here and go through the whole thing again. Perhaps it would be better to have those who can be here and let the entire committee have an opportunity to decide.

Mr. Mitchell: That is fine.

Mr. Chairman: Does that meet with the approval of the committee?

Mr. Turner: Except that I will not be here.

2:40 p.m.

Mr. Baetz: Do you mean to pick the people? I think we have to have considerable confidence in the subcommittee. In a meeting such as this, it is very hard for nine or 10 people to select staff, but the subcommittee should receive some pretty strong direction and indication from this group today to say that when it gets on to the business of selecting the staff, it should start with as big a group as it can, become intimately acquainted with their background and make a selection in that way. The full committee will have to give approval to the staff.

Mr. Chairman: Can I have a motion one way or the other? I did not read the committee's consensus on this point.

Mr. Mitchell: This is one time I am going to disagree with my colleague, Mr. Baetz, but only to this extent. As I said before and I hate to repeat it, I think the steering committee vets a list and comes up with a short list of people it feels it has been able to do research on and who it feels will meet the requirements of this committee. Ultimately, that short list will come here to the whole committee and the members will ask the normal questions. This does not take away from the subcommittee. It is merely saying, "We confirm this one and this is one of the groups you sent on the short list." I do not see it reacting or reflecting in any way.

Mr. Baetz: That is essentially what I said.

Mr. Turner: You do not disagree.

Mr. Baetz: No, he agrees with me.

Mr. Mitchell: Whatever you say. There is nothing like being very agreeable on a hot day.

Mr. Chairman: I do not know whether other chairmen have said this, but I have found that if more than one person speaks at a time, it has Hansard's head spinning. I am waiting for a motion from the committee in regard to how we do this. Do we do it in the way suggested by Mr. Baetz?

Mr. Turner moves that the subcommittee be empowered to meet with and talk to the various individuals and make recommendations back to the committee.

Mr. D. S. Cooke: In the first week of August?

Mr. Turner: Yes, in the first week of August.

Mr. Chairman: Are there any further comments?

Mr. Baetz: I only wonder whether as part of that recommendation the mover will agree that the committee be informed or be instructed to cast its net as widely as possible.

Mr. Turner: Yes.

Mr. Baetz: We should make it very clear that is what we want it to do.

Mr. D. S. Cooke: I have found from phoning around in the past couple of weeks that there are not a lot of people who have expertise in the area.

Mr. Turner: You are right.

Mr. D.-S. Cooke: Everybody I have talked to has referred to these two people at McMaster University as being the experts in our province.

Mr. Chairman: Will you leave the casting of the net to the subcommittee as to how broadly it casts its net?

We have a motion on the floor. Does anyone wish to speak to it? We are going to vote on it then. Is it included in your motion that the subcommittee do it the first week in August?

Mr. Turner: Yes.

Mr. Polsinelli: While I agree with the intent of the motion, my concern is that if the subcommittee reports to the full committee in the first week of August, by the time the staff we choose to hire at that time gets under way and any meaningful deliberations with this committee take place, we will be looking at the fall session. All of August will be gone. I see no problem in having the subcommittee choose whom we will hire. I have confidence in our representative on it and I am sure the Conservative members have confidence in their representative. I do not think there is any reason for him to try to convince me that he has made an appropriate decision. I believe and I am sure that he will make an appropriate choice.

Mr. Chairman: I gather you are speaking against the intent of the motion.

Mr. Polsinelli: I am not speaking against the motion. I am just indicating my point of view. It differs somewhat from the motion.

Mr. D.-S. Cooke: The time frame will be exactly the same.

Mr. Chairman: As I understand it, unless there is some amendment to the motion, the subcommittee is to meet during the first week of August and interview the net-casting results. Have we authority to retain someone and then have him get started or what?

Mr. Turner: The motion said to recommend back to the committee.

Mr. Chairman: That is the motion then. Are there any further comments on the motion?

Mr. Andrewes: That latter part is quite important. As a member of the subcommittee, I would not want to make a recommendation and an undertaking without making sure the other members of the committee were in agreement.

Mr. Chairman: That is why I asked if they were ever going to enlarge the motion. If they did, it would give us authority to do that and we would not require that.

Mr. Polsinelli: You could consult on an individual basis. There is no reason to come back to the full committee to rubber-stamp the decision that the subcommittee makes. I would be just as happy to empower the subcommittee to make that decision. I know my colleague will confer with me prior to making a decision on this matter, as I am sure your colleagues will confer with you.

Mr. Chairman: We have had quite a bit of discussion. Mr. Mitchell, do you have anything to say?

Mr. Mitchell: Following Mr. Polsinelli, one of the other advantages of doing it in the way suggested by the motion is that with the full committee meeting the day after or whatever in the same week as the subcommittee makes a recommendation and the decision is made, you may have by that time other information available to you by the possible staff. They may want to get into something right away and require that committee's approval to go ahead to do it. The subcommittee does not have that authority to give them that go-ahead.

Mr. Polsinelli: If we are talking about only one day, I do not see any difference. I hope, however, that if the amendment were that the subcommittee be empowered to hire the consultants, it would do so expeditiously and not wait until the beginning of August to interview any possible contenders.

Mr. Chairman: The difficulty, as I see it, with calling the full committee the day after we meet with these people is that we do not know when we are going to meet. It is going to make it difficult for the clerk to notify members of the committee and get them here.

Mr. Mitchell: Not on the notion that you have already given advance notice that you will be meeting with these people during the first week in August and that they hold the first week--either Wednesday or Thursday--to meet. The subcommittee will meet on the Tuesday, which is the day after the holiday. I do not see it as a problem. I am perhaps speaking too much as a substitute.

Mr. Chairman: The clerk is going to read the motion so that we are clear on it.

Clerk of the Committee: Mr. Turner moved that the subcommittee be empowered to interview prospective health consultants during the first week in August and make a recommendation to the full committee that same week.

Mr. Chairman: You have all heard the motion. Those in favour of the motion? Carried.

Mr. D. S. Cooke: Unless there is some radical change by the committee, I suggest that the committee meet in the last week of August to get initial briefings by the ministries and to meet with staff.

Mr. Chairman: Mr. D. S. Cooke moves that the committee meet in the last week of August to get initial briefings by the ministries and to meet with staff.

Mr. Andrewes: I want to say a word or two on that. I would like to hear from Mr. Cooke how extensive a briefing he expects the committee to get in three to four days, as well as having a meeting with its staff.

Mr. D. S. Cooke: We can have another meeting if we like. That is fine. We can ask the whips for a further meeting in September and do that one week with the ministries. From what you were saying earlier, I envisioned that the ministries would give us an indication of what current policy is, what pieces of legislation we are dealing with and how extensive, to their knowledge, is the involvement of the private profit commercial organizations in the health and social service field in our province. If that would take the entire week, then we should look at having another meeting of a couple of days or so with staff in September.

Mr. Chairman: Can we go back for a second to clarify? When we are talking about weeks, what days are we talking about, Monday through Friday or Monday through Thursday? We should agree first to find out what kind of weeks we have.

Interjection: Monday through Thursday.

Mr. Baetz: Tuesday, Wednesday and Thursday.

Mr. D. S. Cooke: The committees are scheduled to meet Monday to Thursday.

Mr. Turner: Are they?

Mr. Chairman: Perhaps we need a motion.

Clerk of the Committee: You do not need a motion; you just need agreement.

Mr. Chairman: Do we have agreement for Monday through Thursday?

Mr. D. S. Cooke: We do not have to meet on Monday at 10 a.m. As an out-of-town member, I find two o'clock fine. We are going to meet for only a couple of weeks. We should try to make use of the week as much as possible.

Mr. Chairman: Let us clarify that. Monday through Thursday, starting at 2 p.m. on Monday, or do you wish to start at 10 a.m. on Monday and go through?

2:50 p.m.

Mr. Reyecraft: I prefer 2 p.m. on Monday.

Mr. Chairman: Two to four on Monday and 10 a.m. to noon and two to four on Tuesday, Wednesday and Thursday. Is there agreement on that? All right.

Mr. Andrewes: Mr. Polsinelli and I worked together on another committee and we had much longer hours.

Mr. Chairman: There has also been a suggestion by Mr. Cooke that we meet during the first week after the subcommittee has met with the proposed hires and not during the subsequent weeks before the last week in August.

Mr. D. S. Cooke: Right.

Mr. Chairman: Would anyone have any difficulty if, in lieu of the week of August 25 through August 29, it was August 18 through August 22?

Mr. Turner: Are you speaking of the week of August 4?

Mr. Chairman: On the week of August 4, the subcommittee will meet and interview the hirees and we will meet that week to confirm that. According to Mr. Cooke's suggestion, we would not meet again until August 25 through August 29. I am asking, in lieu of that, to meet either August 11 through August 15 or August 18 through August 22, but I understand there is some difficulty with that.

Mr. Poirier: We have other committees also.

Mr. Chairman: You have other committees?

Mr. Poirier: Of course.

Mr. Chairman: You should not have if you were allocated to this committee.

Mr. D. S. Cooke: If we are only going to meet two out of four weeks in August, why not crunch together the two weeks we are not going to meet?

Mr. Chairman: Are you suggesting we go from August 4 through August 14?

Mr. D. S. Cooke: No, I am suggesting the first week and the last week.

Mr. Turner: What would happen if we met on the week of August 11 as well as the week of August 4 and took off the last two weeks?

Mr. D. S. Cooke: Yes, the last two weeks off.

Mr. Andrewes: The difficulty is that does not give the staff any chance to be involved in the discussions.

Mr. Chairman: If the clerk were to notify the ministry that we will require them to start on August 11, they would have between now and then to put the stuff together.

Mr. D. S. Cooke: It makes sense, if we hire staff in the first week, that to the best of our ability we make it possible for them to attend the briefings by the ministry.

Mr. Andrewes: It would be presumptive on our part to think that staff potentially hired on August 5 would be available the next Monday morning to work on behalf of the committee.

Mr. Chairman: There is still a motion on the floor by Mr. Cooke that the committee invite the Ministry of Health and the Ministry of Community and Social Services in the last week of August to do briefings.

Mr. Polsinelli: I suggest we leave that in the hands of the steering committee in terms of the days of sitting and the items we will be discussing on those days.

Mr. Chairman: Now we have another comment on Mr. Cooke's motion.

Mr. D. S. Cooke: I do not mind doing that. I thought it would probably be helpful to committee members. If there is a change from the steering committee, we can do that; but why do we not tentatively look at the last week of August? At least people will know we are not going to meet in the middle two weeks and if they want to make plans to do something else, they can.

Mr. Chairman: Are you content with that, Mr. Polsinelli? We can leave it in the hands of the steering committee and, if there is a change, we can change it.

Mr. Polsinelli: I am easy.

Mr. Chairman: All in favour of that? Carried.

Mr. Andrewes: I realize you are setting the agenda here, but I wonder if we might have some discussion of what we will require the ministries to report to us. We can do that either after you discuss the budget or whenever you see it as appropriate.

Mr. Chairman: We can do it now if you like.

Mr. Andrewes: It is very important that we give the ministries some direction and time allocation so they can have the appropriate staff here. It is also important that the appropriate staff be the key staff within the areas of operation in which the committee is interested and that the direction we give them be specific enough so they can frame their comments in such a way that we can get some consistency out of the briefing session and put together some sort of binder afterwards that can be a guide for this committee in its continuing work.

I suggest we provide the two ministries concerned--and there may be others, but the two ministries that come immediately to mind are the Ministry of Health and the Ministry of Community and Social Services--with an overall framework that would encompass both the private sector social services and the public sector social services. Within the definition of the private sector, I would include two subareas, private sector for profit and private sector nonprofit. It is important that we have both to make that comparison.

I further suggest that we set out for ministry review six areas under which we will ask them to report to us:

1. Acute care.

2. Chronic care and care for the elderly.

3. I have not reached an appropriate title for this, but I am calling it clinical medicine, whereby it is medical care provided off the street to individuals who may come into a clinic that is sponsored by trade unions in some cases or a group of medical practitioners in other cases.

Mr. Turner: A health centre.

Mr. Andrewes: Yes. A community-based health centre.

4. Alcohol and drug rehabilitation. There is a definite role here for the public and private sector, the private sector being both profit and nonprofit once again.

5. Mental health.

6. Other services, including auxiliary services, particularly laboratory services and the role of the public and private sector there, in both the profit and nonprofit jurisdiction.

I suggest these ministries define for us the acts under which they are operating and the services that are delivered under each act. They should do this with the use of flow charts, overheads and whatever other materials they find useful. As I said, the outcome of all this briefing should be some type of co-ordinated document, binder or textbook for this committee to use as a reference point for further work the committee might pursue.

Is that too complicated?

Mr. D. S. Cooke: To do the same type of thing for the Ministry of Community and Social Services?

Mr. Andrewes: Yes. My intent here is that both the Ministry of Health and the Ministry of Community and Social Services use that common framework. I know the Ministry of Community and Social Services has no role in acute care, but it certainly does in care for the elderly and to some degree in clinical medicine. It has a role in mental health, having jurisdiction over the organization for the mentally retarded. It has some direct involvement in the other services, perhaps not to the same degree as the Ministry of Health, but to some degree.

3-p.m.

Mr. D. S. Cooke: That makes sense.

I wonder if there could be one thing added. I am not quite sure how to frame it, but something that would give us whatever information the ministry has on concentration of ownership. I am thinking of the nursing home industry. It would be helpful if we knew the extent of ownership by local people, for example, who own one nursing home as opposed to the chains that own several. I do not think the ministry would have all the information. That would include the day care industry as well. I do not think the minister would have all the information on concentration of ownership where the private for-profit sector exists.

Mr. Chairman: I leaned over to the clerk to see if she had that all down, and she said she does, which amazes me.

Clerk of the Committee: Do you want me to read it back?

Mr. Andrewes: I have some very sketchy notes, which may be helpful.

Mr. Chairman: Let her read it back and see if it fits the bill.

Clerk of the Committee: That the committee provide the ministries of Health and Community and Social Services with an overall framework that encompasses the private sector and social services; that is, the private sector for profit and the private sector for nonprofit as well as the public sector.

There are six areas in which the ministries should concentrate their presentation: (1), acute care; (2), chronic care and care for the elderly; (3), clinical medicine, output, storefront clinics.

Is that getting what you want?

Mr. Polsinelli: Maybe "community health centres" is better terminology.

Mr. Andrewes: Storefront or community health centres?

Mr. D. S. Cooke: Okay. CHCs and health service organizations, because they are different.

Clerk of the Committee: Continuing: (4), alcohol and drug rehabilitation centres; (5), mental health; (6), other services including auxiliary services; that the ministries define the acts under which they are operating and services delivered under each act, and that the outcome of these things should be co-ordinated in a document for the committee's reference, such as a binder.

A seventh one was added by Mr. Cooke asking how extensive the concentration of private ownership should be.

Mr. D. S. Cooke: There may be an eighth one, children's services, if we are doing the Ministry of Community and Social Services.

Mr. Andrewes: The mandate calls for the committee to concentrate on social services.

Mr. Baetz: If you go beyond health, you are immediately into the whole question of day care.

Mr. D. S. Cooke: Yes. That is why I mention children's services. We will want to look at day care.

Mr. Andrewes: Human services, I think.

Mr. Baetz: The mandate of the committee gets to be very broad if we spill out into that area.

Mr. D. S. Cooke: That is why we need staff.

Mr. Baetz: And time.

Mr. Chairman: By the way, I gather you all know Bob Gardner from the legislative library research, who is here.

Mr. Andrewes: May I ask what the eighth one was?

Mr. D. S. Cooke: Children's services.

Mr. Chairman: Mr. Poirier moves that the interim and final reports of the select committee on health be made available to the general public in both English- and French-language versions and that the translators be allowed to start translation on these reports as soon as possible while the final drafts are being written so that the French-language version be available for distribution at exactly the same time as the English-language version.

Mr. Chairman: That will have to be added to the budget.

Mr. D. S. Cooke: However, we are saving them lots of money by not meeting as often as we were going to this summer.

Mr. Chairman: Does that motion carry?

Motion agreed to.

Mr. Poirier: Here is another point. Depending on which cities this committee will visit and how many public hearings it will have, if it is going to go into some of the bilingual parts of Ontario, may I recommend that we look seriously at simultaneous translation for those groups or individuals who would want to come forward and make presentations, as we have done in past committees.

Mr. Polsinelli: Of which you have been a member.

Mr. Poirier: Of which I have been a member.

Mr. Chairman: Would you like to include that in your first motion?

Mr. Poirier: We might want to look at it when we consider where we will go--obviously not today.

Mr. Chairman: We are going to look at the budget today.

Mr. D. S. Cooke: We are not going to be travelling until next winter, but when we do travel or if there are groups that come before us here, it is normal that simultaneous translation would be provided.

Mr. Poirier: If we make a provision to look at the budget again at such time, I am willing to wait for it at that time.

Mr. Andrewes: Further to Mr. Poirier's comment, the budget we strike now is for the fiscal year 1986-87, and has to last us until the end of March 1987. I got caught in a similar situation with another committee and we had to go to the Board of Internal Economy and ask for \$80,000 or \$90,000 that we had already spent.

Mr. Poirier: Which we do not want to do.

Mr. Andrewes: It was a little embarrassing.

Mr. Poirier: Right. Therefore, to save this committee embarrassment, maybe we should look at this provision right now.

Mr. Chairman: Are you moving that as a motion?

Clerk of the Committee: It is going to be difficult to budget for simultaneous translation for a trip the committee might take and for a place to which the committee might go. It is difficult to add that into this budget.

Mr. Poirier: May I suggest that we look at some places to which we might be going? We could make a supplementary budget and if we do not use it, we shall be very happy and honoured to return it to the Legislative Assembly.

Mr. Chairman: You have heard the motion by Mr. Poirier and the difficulties indicated by the clerk. Is it the wish of the committee that we discuss this? It is very difficult to discuss where we will travel without the benefit of the consultant.

Mr. Polsinelli: Frankly, I do not see any point in discussing now

whether or not we will need additional financing for simultaneous translation at some future point. We will know of any travelling and the locations to which this committee may go well in advance. At that point, I do not see any problem in going back to the Board of Internal Economy with a supplementary budget for the services Mr. Poirier is requesting.

Mr. Chairman: Mr. Andrewes's comments about how much that supplementary budget would be--

Mr. Polsinelli: Mr. Andrewes's comments dealt with a situation where the funds had already been expended and they went back to the board to get the funds they had already spent. I am suggesting that when we decide to travel, at that point we determine whether or not we will require simultaneous translation and we approach the Board of Internal Economy for additional funding for the services at that time.

Mr. Chairman: Are you content with that, Mr. Poirier?

Mr. Poirier: I am content with that if the former members can agree that this is not going to cause the Guinness Book of World Records to enter the expense of this committee.

Mr. Andrewes: I am quite content with what everyone else is content with. It is you who has to go before the Board of Internal Economy, Mr. Chairman.

Mr. Poirier: May I move that if and when this committee decides to go and makes a list of places to go, this committee provides simultaneous translation in those areas designated as bilingual in Ontario? That would cover the basic intent of this committee and when we make the list of whatever cities--Ottawa, Sudbury or wherever--where there might be bilingual groups, then at least we will have covered our intent in a motion.

Mr. Chairman: I was going to ask the clerk if it is possible to put a footnote on the original budget application, more or less in those terms: that it may be the intent of this committee to travel and it may require simultaneous translation. This would serve to alert them to the fact that we are looking at that. They cannot really cut us down afterwards.

Mr. D. S. Cooke: We are also going to have to put a footnote on it saying that we are going to be asking them for only two or three weeks of per diems, whatever the final decision is, and the committee is going to be meeting in January and February, for which we have not budgeted per diems. You are going to have to go back to the Board of Internal Economy in any case.

Clerk of the Committee: Based on the committee's decision today, this budget will now be revised because there obviously will not be five weeks of hearings during August and September and obviously it will not be doing any travelling during August. Therefore, that will be revised. As well, there will be an additional cost estimate for the translation of the interim and final reports.

Mr. Chairman: Can we do it by way of footnote, that we have decreased the number of weeks we are going to sit, that we may be travelling in the future and we are alerting them to the fact that we may require simultaneous translation? Mr. Poirier is being kind enough to go before the Board of Internal Economy tomorrow and he can dazzle them with en français--

Mr. Poirier: Of course; I can dazzle them in any language.

3:10 p.m.

Mr. Chairman: Is the committee in agreement with that approach?

All right. Having done all that, next to the final item to be looked at is the question of the budget. The clerk has already indicated, as a result of our meeting today, the budget may very well be changed; I suppose only with reference to the per diems.

Mr. Reycraft: Before we get into the budget, I note that we have a letter before us from Dr. Gardner indicating that a review of background material has already started. I am thinking of the summer schedule we have been discussing, and how soon we may expect the legislative library to have available for us research material, a compendium of recent research that has already been done in Canada that the committee members could make use of to prepare for the presentations that are going to be made in late August.

Dr. Gardner: In my letter to the chairman, I just wanted to say that we have a person who was beginning to familiarize herself with the area. We have not begun a particular project. We are at the committee's direction on that. If the committee wishes us to prepare some background material, we can go ahead and do that. We have not yet begun anything specific at this point.

Mr. Chairman: It is Ms. Cathy Fooks, I understand. In my naïveté, I had suggested to my two cohorts on the steering committee that something the legislative library might start now would be a compendium of all the acts under which services are provided, either through the government or through the private sector, so that at least we would have some idea.

Mr. Cooke thought that may be precipitate, that doing that in advance of the consultants coming in might be a waste of our time. I do not imagine that would start much before the middle of August anyway. We could call you back if that were not a good idea.

Dr. Gardner: We could wait on your direction. As a consultant is hired and as the role of the consultant is laid out a bit, one of the questions we would need to address is our role vis-à-vis the consultant in serving the committee. As that got clarified early in August, we could be doing any other background material. As to the legislation that will govern this issue, in some ways the ministry will be able to provide that material and kind of question directly. We could do it but it may be efficient to let them do it as well.

Mr. D. S. Cooke: That was outlined in Mr. Andrewes motion, which I assume members have voted on.

Mr. Chairman: Not yet, it is still on the floor. I am sorry, we did not vote on that. Would you like it read again or is one reading sufficient?

Mr. Andrewes: Second reading.

Mr. Chairman: It has been read once.

Mr. Baetz: Dispense.

Mr. Chairman: "Dispense," I hear from Mr. Baetz. Is it agreed that it be dispensed? Agreed. Those in favour?

Mr. Andrewes: It is a motion of sorts. I expect the clerk has done a very good job of putting down my thoughts but I have had some afterthoughts. We may want to add other things. The ministries should be asked to comment on the concentration of ownership, financing options, regulation, levels of service and accessibility. There may be others we want to add to that list.

Mr. Chairman: How about a basket clause covering such further and other areas as may come out during the briefings?

Mr. Sargent: As an aside, are we trail-breaking here? Is there anything parallel to this in any other federal or provincial jurisdiction?

Mr. Chairman: You are asking the wrong person. I believe there was a study for the Department of National Health and Welfare, not necessarily along the same line but somewhat parallel. You would have to ask the heavies on the committee who know all about this stuff. I refer to the fellow pouring water there and the other fellow to his left.

Mr. Sargent: As to that budget thing, add air-conditioning and some cold beer or something.

Mr. Andrewes: You are not speculating on my mass here, are you?

Mr. Chairman: Not at all. I would never make any personal observations, although--

Mr. D. S. Cooke: Let us carry this motion.

Mr. Chairman: Are we going to add the basket clause, "such further and other issues as may come out during the briefing"?

Mr. D. S. Cooke: I am sure the ministry staff will be before us again.

Mr. Chairman: We are not adding that then. You have heard the motion. Those in favour? Carried. The clerk's eyes have just rolled around in her head; I do not know why.

I think the air-conditioning is a marvellous idea, and cold beer is another.

Mr. D. S. Cooke: I move approval of the budget with the amendments that reflect the agenda that is still to be adopted.

Mr. Chairman: Let me find out what kind of exercise that creates for the clerk.

Mr. Cooke moves adoption of the budget, as presented, subject to the amendments that may be required in the light of the things that have been said here today.

Are there any comments, concerns or helpful suggestions that might be interjected at this point?

Mr. Sargent: To satisfy Mr. Andrewes's concern, why do you not notify the boys upstairs that we will need more money later on?

Mr. Chairman: I assumed that is what Mr. Cooke was saying, including the footnotes we discussed about the possibility of travel and simultaneous translation and the fact that we have reduced the per diems because of the shorter sitting period. I assume those are in his motion.

Clerk of the Committee: Can I suggest the wording, that the budget be amended to accommodate decisions made in this committee today and that the chairman be authorized to present the budget to the Board of Internal Economy?

Mr. D. S. Cooke: Exactly what I said.

Mr. Chairman: And in place of the chairman--

Clerk of the Committee: No, it is okay.

Mr. Chairman: Is it? I do not want to place myself on the hook and then find I am not there.

Motion agreed to.

Mr. Chairman: With the exception of the subcommittee perhaps sticking around to decide, I guess we will not know. We will have to leave it at the call of the clerk as to when we will meet with these groups, but it will be during the first week of August after the Civic Holiday.

Mr. D. S. Cooke: The only names I have to suggest to the clerk are Greg Stoddart and Roberta Labelle. I suggest the clerk contact them as soon as possible to schedule them for the first week.

Mr. Chairman: For clarification, Mr. Andrewes, do you have any names to recommend?

Mr. Andrewes: You have received a letter from the Canada Consulting Group, which may or may not be able to provide the kinds of services this committee is looking for. It might be in order to satisfy the concerns of some members that the basket be large enough. We may want to pursue that as a subcommittee.

I have no other names to put forward at this stage. I notice Mr. Cooke has included two other names here, people who have been referred to us as potentials. Mr. Turner has mentioned the name of Bob Evans, an individual I do not know.

Mr. D. S. Cooke: I do not know him either. When talking to Stoddart or Labelle, the clerk could refer to Bob Evans. I always thought he made sausage but--

Mr. Turner: Come on.

Mr. D. S. Cooke: If they all work together, I am sure they are aware of him.

Mr. Chairman: Mr. Turner, you have your hand up.

Mr. Turner: That is what I was going to mention.

Mr. Chairman: Are there any comments from my confrères to the far right?

Mr. Andrewes: Far right?

Mr. Chairman: They are sitting on the far right.

Mr. Turner: They are far right too.

Mr. Chairman: Any suggestions there?

3:20 p.m.

Mr. Mitchell: I happen to feel that when we are dealing with what is going to be a contentious area of health care and community program delivery, the consultants we have to assist the committee have to be selected very carefully. Perhaps it is not too late, but something this committee should have decided much earlier to do, although I know it was not empowered to do so, was to put a notification in the newspaper saying what we were looking for or requiring consultants.

It is the same as most municipalities do for consultants. Either that or there is a lengthy list from which they choose. It is a personal feeling of mine, but I think we ought to have sufficient numbers to make sure that in our examination of them we are comfortable in our own minds that we are selecting the best, that we are not dealing with one or two people and saying we are taking the better of the two. I never have liked the feeling of taking one as the better of two. That is the only comment I wish to make.

Mr. Baetz: My concern about casting a wide net stems back to the point of Mr. Mitchell's.

Mr. Chairman: That is an old fishing expression, is it not?

Mr. Baetz: I have never had experience on a select committee. I do not know how it goes out to tell the world there is to be a job done that requires a certain expertise and that people who feel they are qualified should be given an opportunity to get in touch with the committee.

I think that is very important. It is fine for one or two members of the committee to say they happen to know somebody. That is good. I am not knocking that at all. It is a very fine initiative, but I get the feeling that in making sure we can get the best qualified help possible for this very important task we should, in a more methodical way, see what is there in the expertise field.

You have been chairman of a select committee. I do not know how select committees operate. I have been active in another part of the Legislature.

Mr. Chairman: We select a consultant.

Mr. Baetz: But what is the modus operandi the select committees go through? For instance, are there public announcements that the Ontario Legislature is now going to embark on this important assignment?

Mr. D. S. Cooke: This is how it is usually done.

Mr. Baetz: Through word of mouth or hearsay?

Mr. D. S. Cooke: If you want to advertise in a newspaper, that is great, but you might as well put a few more per diems in there because we are

going to have a hell of a lot of people to talk to, including people who are completely inappropriate.

Mr. Andrewes: I would have to agree with Dave. To allay the fears of my colleague, we are sitting here as 11 members of a committee, including the chairman. We all probably have different views and ideas on the subject at hand. The staff acts at our direction. If they carry a certain bias with them, it is incumbent on us to make sure that bias is not leading the committee. In other words, we lead the staff; the staff does not lead the committee.

I hope that in looking at staff we can be concerned, not so much in terms of their ideology as with their ability to understand public policymaking, to understand the realities of a partisan committee, to understand the object of the exercise and to be able to assist in the composition of the report. The success of this committee, in years to come, will be determined by the quality of its report.

Mr. Baetz: I agree with your observation. I am not really concerned that somebody with an enormous bias is going to be able to inject the bias in an uncensored way into our final report. I am not worried about that at all. My only concern is that there must be in this province, and are by now, quite a few people with some very advanced skills in this difficult field. My concern is that they would not find out what is going on right now. If, in bygone days, select committees have included staff in a more informal way and it has worked, that is fine.

Mr. Chairman: Perhaps one day we will have a select committee on consultants.

Mr. Mitchell: I have one final comment. It is not the issue of biases that I am directly concerned about, although when I look at the people on this list of possible consultants, they are, with the exception of one, all involved somewhere within the field of health or social services. I am not always sure they can see in any other direction but the direction they are in.

Mr. Turner: That is what they are hired to do.

Mr. Mitchell: I do not mean it as bias, although in a way I suppose it is. Surely there are people outside of those involved in the health care field who would be able to step back a little and look at a report from the Ministry of Health which intended to broaden the amount of commercialization in the provision of health care.

I like to think that there is somebody out there who is standing back and who can look at it without feeling that he is caught in something because of a possible vested interest, i.e. he is involved in the field. I do not know where epidemiology would fit in this, but certainly, this could very well apply in social sciences.

I agree with Reuben about the wider basket. I do not know how you do it and allow the committee to function as best it can in the time frame that it is establishing for itself.

Mr. D. S. Cooke: Leave it to the subcommittee. We will convince you that we have done it.

Mr. Mitchell: I am not saying I do not have faith in the subcommittee. You are getting into dealing with something that is very crucial. I would like to feel that it is being done right.

Mr. Poirier: I agree that it is very crucial, but each coin has two sides; one is called bias and the other is called expertise. At which point do you flip the coin over?

Mr. Mitchell: That is true.

Mr. Poirier: I do not know myself.

Dr. Gardner: Perhaps I can speak to some of these concerns. One of the roles that the research service can play is being able to step back and provide that general view. In our experience of serving committees, we can fill that role, while still having the detailed expertise that we do not have provided from the outside. We can balance those things off by ourselves and the outsiders being there.

Mr. Chairman: I cannot speak for consultants, but in the legal profession you can have all the biases in the world you want and probably represent both sides of that coin equally effectively.

Mr. Turner: Or both.

Mr. Mitchell: I thought the legal profession could make both sides look good.

Mr. Chairman: They can usually do that too, standing on their heads.

Mr. D. S. Cooke: Are we looking at a request to the whips for potential meetings in September, or do we want to leave that at this point?

Mr. Chairman: You are a whip, and so is Phil.

Mr. Andrewes: No, I am not.

Mr. Chairman: Oh, you are not? From what I can figure, my perception is that all the dates are filled.

Mr. Mitchell: I know that no more than two committees can sit on estimates at any one time. What is the rule on committees sitting?

Mr. Chairman: There is no rule.

Mr. Turner: I do not think so.

Mr. Mitchell: I thought it used to be no more than three committees sitting at one time.

Mr. Chairman: It is logistics more than anything else.

Mr. Mitchell: Okay.

Mr. Chairman: We could perhaps solve that with an election.

Interjection: All agreed?

Mr. Chairman: I did not mean to say that.

Mr. Turner: Gee, we were getting along so well.

Mr. Chairman: There is nothing further, is there?

Mr. D. S. Cooke: I understood we were having an election.

Mr. Chairman: I thought there was an accord.

Mr. D. S. Cooke: I am talking about the north.

Dr. Gardner: I wonder whether I can take away some direction from the committee on what role the legislative research service will play here. We will assign a research officer. That person will, under the committee's direction, be prepared to draft either the interim or the final report, if you wish. As you are hiring consultants, this is something you can be aware of, that we can do this kind of thing. We commonly do it.

3:30 p.m.

In the public hearings that are to be held in January or February, we would summarize the evidence presented on an ongoing basis, so that you would have it before you. We can do any number of other background material searches that you may wish. Our intention is to have a person who will be with you in the hearings from start to finish.

Mr. D. S. Cooke: Whatever consultants we talk to in the first week of August, one of the things that would be useful is if the legislative library could try to pull together for us whatever background material is available on them for the steering committee.

Mr. Chairman: That is a good point.

Dr. Gardner: Certainly.

Mr. Poirier: Bob, would you like us to endorse the mandate you are asking for in your letter to the chairman?

Dr. Gardner: Not really. I am sorry. I did not mean to be presumptuous in that. It was not so much asking for a mandate as telling the committee what we have done in the past and what we can do at your direction.

Mr. D. S. Cooke: I assume we want a legislative library research person attached to the committee.

Mr. Poirier: Definitely.

Mr. Chairman: Of course.

Mr. Poirier: Whether you are asking or not, would you like me to put forward a motion that we adopt that?

Mr. Chairman: I think we can give this direction to the legislative library. It is looking for direction and I think Dr. Gardner has it now.

Dr. Gardner: Yes.

Mr. Chairman: We would look at all of those aspects and anything else he has to offer.

Dr. Gardner: Our person will be at the disposal of the chairman, the subcommittee and the full committee, as you require.

Mr. Poirier: Fair enough.

Mr. Chairman: Is there anything further? Is there any further good for the club?

Mr. Turner: Concurring with an observation Mr. Cooke made earlier, I think the expertise of a number of people in this field may be limited. As a general observation, I suggest we may have to look, in some cases, far afield or further afield than we normally would for that direction and expertise. I throw that in for what it is worth.

Mr. Sargent: I agree with John. I still recall that we had the best experts in America available to us on the select committee on energy. There must be a lot of new ball games along these lines in major states such as New York and Illinois where we can get specialists. As John says, it is important that we look farther afield to get new ideas on how they go about things.

Mr. Chairman: Hawaii?

Mr. D. S. Cooke: It will be very interesting if we get into one of the areas outlined in Mr. Andrewes's motion of community health centres and health service organizations. In our local paper on the weekend, the front page story was about how all the doctors in Michigan are complaining about lack of control and how government is taking over their practices through the HMOs. They all want to quit and come to Canada.

Mr. Turner: Is that right?

Mr. Andrewes: May I read something into the record here?

Mr. Chairman: It all depends.

Mr. Andrewes: It is very brief. It is an excerpt from a very unbiased report, the source of which I will provide you with in a minute. It says:

"Privatization in the Canadian Health Care System, a study done for Health and Welfare Canada by G. L. Stoddart and R. Labelle, McMaster University, in October 1985 concluded that the privatization debate is primarily one of ideology as opposed to one of hard evidence on either side."

That comes from the well-known report of Erik Nielsen to his colleagues in the federal House.

Mr. Baetz: Who is he?

Mr. Chairman: Who is Erik Nielsen?

Mr. D. S. Cooke: Let us just hire them. We might even be able to get Erik Nielsen.

Mr. Chairman: In light of that last comment, perhaps we can adjourn the committee now and for ever.

In any event, are there any further comments, any further pearls of wisdom or any further quotes from renowned Canadians?

Mr. D. S. Cooke: What do you mean by any further quotes? How about one?

The committee adjourned at 3:35 p.m.

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SELECT COMMITTEE ON HEALTH

COMMERCIALIZATION OF HUMAN SERVICES

MONDAY, AUGUST 25, 1986

SELECT COMMITTEE ON HEALTH

CHAIRMAN: Callahan, R. V. (Brampton L)
Andrewes, P. W. (Lincoln PC)
Baetz, R. C. (Ottawa West PC)
Cooke, D. S. (Windsor-Riverside NDP)
Johnston, R. F. (Scarborough West NDP)
Poirier, J. (Prescott-Russell L)
Polsinelli, C. (Yorkview L)
Reycraft, D. R. (Middlesex L)
Sargent, E. C. (Grey-Bruce L)
Stephenson, B. M. (York Mills PC)
Turner, J. M. (Peterborough PC)

Substitution:

Wiseman, D. J. (Lanark PC) for Mr. Turner

Clerk: Deller, D.

Staff:

Fooks, C., Research Officer, Legislative Research Service

Witnesses:

From the Ministry of Health:

LeNeveu, R., Assistant Deputy Minister, Administration, Finance
and Health Insurance

Psutka, Dr. D. A., Assistant Deputy Minister, Emergency Services,
Laboratories and Drug Programs

LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON HEALTH

Monday, August 25, 1986

The committee met at 2:07 p.m. in committee room 2.

COMMERCIALIZATION OF HUMAN SERVICES

Mr. Chairman: I recognize a quorum. You have an agenda before you, committee. We have before us today Ron LeNeveu, assistant deputy minister, and Dr. Dennis Psutka, assistant deputy minister. Are you gentlemen going to do it together or separately?

Interjection: This is all on the record.

Mr. Chairman: Perhaps we should clear up for the record what you are going to do together. If you would like to come forward, we would be very happy to hear from you.

Mr. LeNeveu: Mr. Chairman and committee members, I would like to thank you for the opportunity for the Ministry of Health to appear before you today and tomorrow.

In the course of the next day and a half, we will be presenting a number of papers. This afternoon, we would like to respond to some of the topics raised in the committee's earlier meetings. We have passed out two papers for your information today, one dealing with laboratory services and the second with emergency health services.

Under tab 1, I believe, if you would look at it, is a little table dealing with legislation. Down the left-hand side, you will notice some topics, such as laboratory services and emergency services. Tomorrow, we would like to bring with us a binder that will have all the papers, including the two we will go over with the committee today. Altogether, there are about 16 or 17 papers in the book. They are all punched and will all be done in the same format as the paper before you. There will be a yellow summary of the paper for the committee's information, then a paper that runs anywhere from half a dozen pages to perhaps a dozen pages or so.

Mr. Chairman: Are we all going to get a copy?

Mr. LeNeveu: Yes. We will bring the binder tomorrow. It will also include the two papers of today.

Mr. Chairman: Fine. Thank you.

Mr. LeNeveu: If I might just touch on the question of legislation, about which the committee had asked, we tried to set out before you two pages dealing with the legislation that covers the Ministry of Health. We can also provide the committee with copies of any legislation it wishes to see. Obviously, the committee has the same legislation available in other ways.

There are about 20 acts on page 1 covering the topics you will be raising in the committee, and there are another almost 20 acts on page 2, which is also legislation within the ambit of the Ministry of Health; some of it is really not that significant to the operations of the Ministry of Health.

As you are aware, the ministry's budget is now about \$9.8 billion, which means the ministry is spending about \$1,000 per capita. The book we are bringing tomorrow will also provide a brief breakdown of our expenditures in the context of the topics we will be covering today and tomorrow.

Mr. R. F. Johnston: Mr. Chairman, is the Hypnosis Act under private or public administration?

Mr. D. S. Cooke: Are they allowed to extra bill?

Mr. Chairman: I am sure that will all come to us in the fullness of time.

Mr. R. F. Johnston: How will we know when we are hypnotized and when we are not? That is the problem.

Mr. Reycraft: The intriguing question is, which one of the gentlemen on the far side has the cough drops today?

Mr. Chairman: We have sat for only three days, and this committee is already out of control. Will you please continue? Just ignore these people unless they ask something pertinent or relevant.

Mr. LeNeveu: I do not think I would like to say much more. I will ask Dr. Psutka to walk through the first paper on laboratory services. If it is the wish of the committee, we could walk through the paper and answer questions as we go along, or if you would prefer, Dr. Psutka can go through the paper and then we can go back and try to expand.

Since we are covering quite a number of topics today and tomorrow, we were hoping to meet your timetable if we can get through these two today and then the topics tomorrow morning. You will notice we have nursing homes at the end. We could take the topics in any sequence you like tomorrow, but we put nursing homes at the end because I think that will be the one where there will probably be more questions and conversation.

Mr. Chairman: I will inquire of the members of the committee. Would you like to have them go through the items they wish to finish today and then have questions afterwards? Perhaps it will expedite matters if we do that.

Mr. R. F. Johnston: One at a time. We should hold questions until the end of laboratory services and then do the other.

Mr. Chairman: Does it sound reasonable to do it at the end of each item? Fine.

Dr. Psutka: The paper you have in front of you on the laboratory services is meant to be a general overview of a very complex area in the delivery of health care in the province. If you will bear with me, I would like to go through it, because there is a whole new vocabulary that has to be learned and made familiar. Otherwise, it is very difficult to understand the whole system of laboratory testing.

Clinical laboratory tests are performed for purposes of diagnosis, prophylaxis, screening, monitoring, prognosis and patient management. There are 553 laboratory tests listed in the schedule of benefits. This schedule published by the government mirrors the Ontario Medical Association schedule, and the tests that are in there are scientifically reliable and reproducible.

These tests are usually done in a variety of settings in Ontario, including hospitals, commercial laboratories, public health laboratories and doctors' offices. There are many factors that play a part in determining where these tests are performed, including the type of patient specimen needed, the quality of the test result, the turnaround time from ordering the test to the availability of the result, the costs, availability of funds, communications, interpretation and even the meanings of the tests themselves.

In Ontario at present, hospital laboratories are primarily geared to servicing inpatients. They also perform tests on outpatients and on hospital staff as part of routine health examinations. In some remote communities, hospital laboratories serve as the only resources for laboratory testing. On the other hand, the private sector is oriented towards tests ordered for patients outside the hospital setting, such as community services, although some of the larger organizations also perform work for hospitals.

Public health laboratories, of which there are 12 throughout the province, mainly perform public health reference specialty work. This includes microbiology and water testing. They also perform clinical work referred from private doctors, hospitals and private laboratories. An increasing number of doctors are also having test analyses performed in their office laboratories, and we will speak a bit about that later on.

In 1984-85, an estimated 127.7 million tests were performed in commercial and hospital laboratories in Ontario at a cost of approximately \$525 million. We will have some further figures for your information as we go through the presentation.

How did we get where we are? I think it is important to have an historical overview, and I guess the system of lab services in Ontario traces its origin to the establishment of the provincial bacteriology lab in Toronto in 1890. Private laboratories have long been in existence, primarily to serve the needs of physicians' office-based practices. With expansion of the hospital sector, particularly since the mid-1950s, hospitals have become major providers of the laboratory services.

In 1969, the Committee on the Healing Arts and the Ontario Council of Health recommended that systems of standards and controls and licensing and inspection for medical laboratories be instituted to ensure the quality of the growing laboratory system. A task force on laboratory services in 1972 recommended that the necessary legislation and regulations for the licensing of laboratories should come into force by July 1, 1972, or as soon thereafter as was possible.

In November 1972, the laboratory licensing statutes were promulgated and with them the Ministry of Health embarked on a three-phase program to develop a laboratory system that was capable of meeting the health needs of the people throughout the province.

In the very first phase, all hospital and commercial labs were identified and issued with provisional licences. The second phase involved inspection of these licensed laboratories, hospital and commercial facilities only, to assess the quality of the individual laboratory operations. The third phase involved the introduction of an external quality control program.

In June 1974, the licensing statutes were amended to provide for mandatory participation by all licensed laboratories in proficiency testing. In that year also, the Ontario Medical Association was designated as the

agency to conduct this program of external quality control. This program is called a laboratory proficiency testing program, or LPTP, and we will talk a bit about that later also.

The laboratory licensing statutes themselves have remained unchanged since 1974. However, in 1983, Bill 64, An Act respecting Certain Health Facilities, including laboratories, came into force, authorizing the Minister of Health to deal expeditiously with facilities whose operations are likely to cause harm or to endanger the safety of persons. Appendix A, which is attached, is a reference list of all the statutes that carry reference to the laboratory practice.

I would like to spend some time on the impact of licensing. While most of the private labs initially licensed in 1972 had been in operation prior to those licensing laws, a significant number opened during the months immediately preceding November 1972. In the two years following the introduction of the legislation, the minister received many more applications for new facilities.

The legislative authority to refuse to grant new licences was difficult to apply. Any applicant who could demonstrate that his proposed laboratory met the requirements of the act and who paid the prescribed licensing fee was entitled to a licence. Therefore, the ministry reinforced the statutes in 1974 to provide the statutory framework to define public interest and to provide authority to approve and issue new licences in a rational manner in response to public needs.

If you go to table 1, you will find a comparison of the number of laboratory facilities licensed at the inception of the program with those in existence now. The number of private labs has decreased by 40 per cent, mainly as a result of voluntary consolidation of testing sites and conversion of laboratories to specimen collection centres. Specimen collection centres are those facilities where people go to have blood drawn and they are then sent from those centres to a laboratory to have the testing done.

The majority of these conversions took place between 1979 and 1983. Many factors prompted these conversions, but the major impetus would appear to have been rapid advances in technology and new automated equipment, which provided rapid processing of a larger number of specimens with greater accuracy and precision. As you can see, the number of hospital labs has remained relatively stable.

Table 2 displays the distribution of the medical laboratory industry in Ontario relative to general population, number of physicians and the volume of services for each of the six health service regions. As you can see, the central-east and eastern regions have the highest number of practising physician facilities and volume of services relative to population.

In 1984-85, the provision of laboratory services could be broken up into the following percentages. The hospital sector was 64 per cent, private labs were doing about 33 per cent, public labs about one per cent of the testing done, and physicians' offices about two per cent.

14:20

Each of the three major sectors of the lab industry has a different funding mechanism. Private labs are reimbursed by the Ontario health insurance plan on a fee-for-service basis and hospitals on a global basis, while public

health labs operate on an annual budget. Doctors are also reimbursed on a fee-for-service basis.

As for private labs, in 1984-86, the ministry paid approximately \$240 million for lab tests performed in commercial labs. The OHIP rate of payment is a negotiated price based on LMS units assigned to each of the lab services listed in the schedule of benefits. There are 553 individual tests, as I stated earlier, listed in the book in various groupings and classes.

The LMS unit structure was introduced in 1974, LMS standing for labour, materials and supervision. A blend of those criteria allows a method of establishing the relative value of laboratory tests. The purpose of the unit was threefold: It established a more up-to-date relative value among the various lab procedures; it allowed people who are negotiating or setting a price to add fractions of cents to all the test procedures by a change in the LMS value multiplier; and it separated out the fee for patient documentation and specimen collection from the fee for tests.

For example, if you went through the schedule of benefits, you would find that a common test, such as a thyroid test, is 24 LMS units and a sugar test is six, whereas something that is very labour-intensive, such as genetic karyotyping of skin cells, is 475 units. As you can see, there is a variation in those units.

LMS units were assigned to each test in collaboration with the Ontario Medical Association. Initially, private labs were reimbursed at 90 per cent of the approved unit rate. From May 1, 1978, however, OHIP published its own schedule of benefits, and since then the payment level has been 100 per cent of the rate published in the OHIP schedule of benefits.

Revisions to the lab fee schedule are negotiated by a tripartite committee with representation from the Ministry of Health, the section of laboratory medicine of the OMA--

Mr. Sargent: Who owns the public labs? Are they owned by a group of doctors?

Dr. Psutka: Private or public? The public labs are government labs.

Mr. Sargent: Private then.

Dr. Psutka: Private are owned by whoever happens to hold the licence. It could be a corporation or an individual, that type of thing.

Mr. Sargent: How many of them are there?

Dr. Psutka: That comes later on in the paper.

The tripartite committee also includes the Ontario Association of Medical Laboratories.

In the negotiation process, an overall percentage increase to be paid on the fee schedule is arrived at first. This is allocated by adjusting the LMS unit value assigned to each test or by adjusting the unit monetary modifier. I think it is currently at 48 cents. This allows for adjustments to the fee schedule to reflect changes in technology and expertise required to perform any given test.

If you go to table 3, you will see that payments and services to commercial labs have been increasing steadily. In the five years from 1979-80 to 1984-85, the number of lab services performed has increased on average by 9.2 per cent per year. These utilization increases are taken into account in the negotiation process. In fact, recognizing the economies of scale associated with the increasing volume of lab tests, the negotiated fee per LMS unit for a lab test has averaged only five per cent during the same five-year period while the average increase in the consumer price index has been 8.4 per cent.

In 1983, a payment utilization factor was introduced. A ministry analysis of the ordering patterns of general practitioners showed considerable variability in the number of lab tests ordered by individual physicians. The Ontario Association of Medical Laboratories and the Ministry of Health agreed that the reimbursement formula should recognize the economies of scale that can be realized in providing services to practitioners with significant ordering patterns.

The formula that was adopted applies to general practitioners, who represent about 80 per cent of the insured commercial laboratory services. The formula pays 100 per cent of the fee for the first 150,000 LMS units, 75 per cent for the next 50,000 units and 50 per cent for units totalling more than 200,000. The formula was introduced retroactive to April 1, 1983. In 1984-85, the net saving was approximately \$4.2 million over what would have been billed if we had left the LMS units as they were.

Turning now to hospitals, the full cost of operating hospital laboratories is included in the global budget of the hospitals to cover inpatient and outpatient services. Some hospitals are also organized to provide outreach services to community physicians through courier systems and specimen collection centres established in their respective communities. Two examples I would like to talk about are the Hamilton Health Sciences Laboratory Program and the Hospitals In-Common Laboratory System, better known as HICL.

In the Hamilton-Wentworth region, the Hamilton Health Sciences Laboratory Program consists of the laboratories that are in place in St. Joseph's, Chedoke-McMaster and the Hamilton Civic hospitals. It includes nine specimen collection centres and one mobile unit. This program also operates a reference centre, which is a clearinghouse for specimens referred by hospitals outside Hamilton. In other words, a smaller hospital, such as in Grimsby or Fort Erie, might refer some of its more esoteric tests to the Hamilton system, which would then determine which of the hospitals that test should go to. The revenues of this program come from a specified portion of the global budgets of the three participating hospitals as well as from revenues received for work performed for other agencies through the reference centre.

HICL is another hospital-based organization which serves as a referral mechanism between hospitals and provides access by community physicians to laboratory tests performed in hospitals. HICL is located mainly in the Metropolitan Toronto area. There are four components in the HICL system; what it has is a very small laboratory with a very limited licence. On the other hand, there is an extensive medical laboratory grid composed of 35 hospitals or hospital-related specialty laboratories. There are another 166 institutes throughout the province which belong to the network grid. Besides that, HICL provides seven community collection centres in various parts of Metro, where it does pickup samples. This mechanism permits a hospital to refer more complex tests to other hospitals within the grid. In that way, hospitals can

use the necessary technical and professional expertise, equipment and capacity to achieve efficiencies within the system. It is important to note that besides servicing hospitals, HICL also provides services to private physicians in some parts of Ontario.

Physicians are another area one should be aware of. Private physicians in Ontario have been performing lab tests in their offices on their own patients. They may charge the rates outlined in the OHIP schedule of benefits. There are 13 procedures listed under G codes, and these apply only to physicians' office testing. For example, urinalysis or haemoglobin, which are very common tests, will be listed under the G codes. Other, more complicated procedures that are performed in physicians' offices in some cases may be billed at the full L code rate. Payments in 1984-1985 were about \$6.5 million for services performed in physicians' offices.

If one looks at Table 4, one will see that the distribution of dollar payments by sector from 1974-75 to 1984-85 has been broken down. Traditionally, the hospital sector has dominated the market, although its relative market share declined from almost 67 per cent in 1974-75 to about 59 per cent in 1985. In absolute dollar terms, however, hospital sector activities have tripled from \$104 million to \$318 million. I think that exemplifies the fact that much more advanced technology is available in hospitals, so the tests are more expensive.

The private sector's relative market share has increased from almost 29 per cent to 38 per cent and in dollar terms has increased by more than four and a half times from \$45.8 million to \$207 million over the same period. The public health laboratories' share, however, has dropped from four per cent to 2.6 per cent. On the other hand, the dollar value did rise from \$6.2 million to \$13.8 million in 1985.

14:30

Looking at the lab industry, there are some trends you should be aware of. The following are a few illustrations. First, there are trends in patterns of ownership. This is in answer to Mr. Sargent's question earlier. In 1977, ownership of all commercial labs rested in the control of 100 corporations, partnerships or individuals. In 1985, 65 owners controlled the private sector, and 77 per cent of these were corporations. In 1977, the largest 10 corporations accounted for 61 per cent of lab services provided by the private sector. However, this figure had risen to 69 per cent by 1985.

On the other hand, there is a trend towards increasing utilization of laboratory tests to reach or confirm a diagnosis, if you will look at table 5. Many reasons have been suggested to explain this recent phenomenon. In 1982, the Ministry of Health and the Ontario Medical Association agreed to join in a special study. This study was known as the Health Services Patterns Project.

Based on the growth rates and lab services, it was agreed that the use of lab services be the first area to be examined in the study. The study explored some of these utilization trends and sought to quantify various factors responsible for differentials in utilization.

Below that we have listed some of the factors identified. They are broken into two major clumps: demand factors, which include population, new technologies and information; and supply factors, which include things such as medical legal concerns, treatment patterns, new technologies and things along that line.

Another trend that is developing and has caused a lot of interest in the past few years is a thing called the black-box explosion. What we have here is the introduction of computerization in user-friendly boxes, as it were, that people can use to do lab tests. Lab instrument manufacturers are developing and introducing a new generation of very compact, miniaturized instruments which employ relatively inexpensive microprocessors with self-contained and relatively stable reagent systems.

These instruments offer a wide variety of lab tests performed automatically and inexpensively. They are being marketed by instrument manufacturers as potentially an ideal alternative for physicians desirous of more rapid analysis in the office than that offered by testing in the traditional hospital or private lab settings. These new instruments, as I said earlier, are referred to as black-box technology. It is our opinion that they will represent a major factor in the future development of the laboratory services sector.

In the literature, however, there is general recognition among health care planners and professionals that these changes in the growing capacity they provide to perform lab tests in the office have raised two major issues that will require future consideration: (1) the assurance of quality in the office setting and (2) the appropriate use of this technology.

Hospitals are also taking a greater interest in establishing co-ordinated services or regionalized programs to share expertise and to achieve greater cost-effectiveness. This trend is evident mainly in small hospitals serving remote communities in the north, which continue to face the chronic problems of being unable to attract or retain qualified personnel.

However, well-established co-ordinated services such as the Hamilton Health Sciences Laboratory Program, which I mentioned earlier, are also functioning in the well-populated south and are serving as examples of cost-effective options to other not-so-remote community hospitals.

Mr. Chairman: Dr. Psutka, I know the committee agreed to wait until the end, but I am wondering whether one of the other concerns in that item of the black box is the potential increase in costs to the Ontario health insurance plan.

Dr. Psutka: That would be a concern. I think "appropriate use" is sort of a catch-all, but that would be one of them. In other words, if it is there and it is user-friendly, why not do it?

2:30 p.m.

Another trend is that the private sector is showing interest in providing services for hospitals. At present, only one hospital in Ontario has contracted the services of a private chain to operate and manage its onsite lab for inpatient services: the Orthopaedic and Arthritic Hospital here on Wellesley Street. However, many large chains have expressed interest in managing hospital labs. No firm proposals have yet been presented to the ministry. There are indications, however, of a willingness on the part of hospitals to assign presurgery and preadmission lab workups to private laboratories.

I have some information for you on licensing and inspection programs. The activities of locating, licensing and inspecting lab testing sites, initiated in 1972, have evolved into the ministry's current licensing and inspection programs.

The primary activity is licensing which, apart from the routine annual renewal of existing licences, also involves preparation of public interest evaluation reports. This assists the minister in exercising his statutory authority to approve or refuse issuance of licences for additional tests to existing programs, new licences, relocations, transfers of ownership, consolidations and so on.

Until amendments to the licensing statutes were made in 1974, the processing of licence applications was based on poorly defined criteria, which amounted seriously to the issuance of licences on demand. The act now provides for a clearer definition of public interest considerations to be taken into account in the evaluation of each new application.

If you look at appendix B, you will see a ministry policy statement which explains those criteria, the way they are interpreted when the ministry reviews licence applications for renewal, change, etc., and results of public interest evaluation reports.

The preparation of public interest evaluation reports is carried out by the lab inspection service. The number of applications for various types and combinations of licensing changes is reported in table 6. You will see that they vary year by year.

I can also inform you that this preparation of public interest reports has grown extremely complex as concentration of ownership of private sector facilities increases and competition among the remaining chains grows more intense.

The laboratory inspection service also conducts inspections of all licensed labs and specimen collection centres. This activity includes investigation of complaints from the general public and inspection of unlicensed testing or specimen collection activities. The lab inspection service is responsible for day-to-day liaison with the Ontario Medical Association's laboratory proficiency testing program, which conducts proficiency examinations of all labs in the province.

As I told you earlier, the public health statutes governing medical labs were amended in 1974 to require that, as a condition of licensure, all labs would have to partake in a testing program to determine that they were providing proficient results. The Ontario Medical Association was designated by regulation as an agency to conduct these exams and to report the evaluations of proficiency to the ministry.

The objective of the LPTP is to assist the labs in maintaining a high standard of service and to protect the public. The association currently conducts proficiency examinations in eight disciplines: bacteriology, chemistry, cytology, genetic cell culture, haematology, immunohaematology, parasitology and radioisotope assays. This program, by the way, is world-class, and it is something this province is recognized for throughout the laboratory industry.

Co-ordination of the program is through the Ministry of Health and the Ontario Medical Association. A conjoint committee that allows the sharing of information is chaired by a Ministry of Health appointee and includes members from both the government and the association. All recommendations regarding the proficiency of labs are handled by this committee.

The funding for the operation of this proficiency testing program is reviewed and approved annually by the ministry. The actual 1985-86 budget was

\$1,631,800, of which the ministry recovered 49 per cent through fees collected from participants. The upcoming budget appropriation has gone up a bit; it is \$1,697,000.

That, Mr. Chairman, is the extent of this report.

Mr. Chairman: Welcome, Dr. Stephenson.

Miss Stephenson: I am sorry. The legal profession kept me late today.

Mr. Chairman: Is that right? They are a nasty bunch.

Miss Stephenson: No, not nasty. Sometimes stupid, but not nasty.

One of my constituents, however, is in deep trouble as a result of the total negligence of her lawyer. That is where I have been.

14:40

Mr. Chairman: I have Mr. Johnston on the list.

Mr. R. F. Johnston: I wonder if we could deal a little bit with the question of concentration of ownership in the private sector. The information you provide on page 8 is fascinating. I wonder if it is easy to get access to more information about the corporations involved.

For instance, is it easy to get a listing of the 100 corporations? Is it easy to find out how many of the corporations are doctor-owned corporations, how many are Canadian or how many are based outside the country? In the second paragraph, about the increase in the percentage of the 10 largest corporations, it would be fascinating to know who they are and who they bought out and to see who is growing in this area. Where can we get that information?

Dr. Psutka: The licensing branch maintains a computer-based information system. Basically, we can provide most of those lists as to who the companies are and who owns them, to the best of our knowledge. In other words, what I have in my database is available.

Mr. R. F. Johnston: I would be interested--I do not know if other members would be--in seeing that broken down a bit. I may not have my ears tuned properly, but you said "to the best of our ability," as I recall. Does this mean that is all the information needed to obtain a licence? It does not require a very full explanation of who the principals are in a corporation?

Dr. Psutka: What I was alluding to there was whatever information I have is available. I do not have other information, if you know what I mean. In other words, we have only what we collect.

Mr. R. F. Johnston: If we could see that and if we were interested in finding out further information than you already have, we could do our own research on top of that. It would be very helpful to get an idea of where the concentration has taken place and who is benefiting.

Mr. Chairman: Would you like a list of the number of points Mr. Johnston asked for? I think he asked for the ownership of the 10 top ones. What were the others?

Mr. R. F. Johnston: Canadian.

Mr. Chairman: Canadian or foreign.

Mr. R. F. Johnston: And the nature of the corporations, whether they are publicly owned or privately owned, how many are doctor-owned--that sort of thing.

Dr. Psutka: We have a scribe who is trying to take this down.

Mr. Chairman: All right. I did not realize that.

Dr. Psutka: We also rely on Hansard, and we will liaise with Mr. Johnston.

Mr. D. S. Cooke: Could I add to this? Would there be any way of getting, on a regional basis, who controls regional markets?

Dr. Psutka: What I can do is tell you who has lab licences by region.

Mr. Polsinelli: Could we have an explanation of what type of information you do have on file? For example, if a corporation applies for a licence, what type of personal information would you request from it?

Dr. Psutka: First of all, we have the owner of the laboratory. We find out if there is a listed medical director or who is responsible for the lab, who works in the laboratory and what their qualifications are. Basically, we also keep track of their proficiency in the various testing programs and what tests they are licensed to do.

For example, of the 500-odd tests, not everyone is licensed to do everything. If one looks at the total aggregate of tests and licences, the average private lab probably is licensed to do between 40 and 50 common tests. Then each laboratory, depending on what it has applied for and what its expertise is, and other criteria such as availability in an area, would have licences granted--

Mr. Polsinelli: I guess my question was more along the lines of whether, if ABC Ltd., as owner, applies for a licence, are you satisfied simply with it being ABC Ltd. or would you inquire as to who the directors, officers and shareholders were or what the past history of that corporation was in terms of licensing?

Dr. Psutka: There are very few new owners in the system. In other words, as you have noticed on the other chart here, the number of lab licences has decreased. There is consolidation, but the corporations are not new to the scene. With a major firm such as MDS, which is a very large firm, we would know the president of that firm and things such as that. It is a public company, if I am not mistaken, and therefore it would have all its board members, etc., available as witnesses.

Mr. Chairman: Perhaps we could wait until we get that information; there may be more questions emanating from that. Maybe there will be none. I doubt it, though.

Interjection.

Mr. R. F. Johnston: What a generous kind of fellow.

Miss Stephenson: This relates to page 8. Could I have one simple

question? How many licences have been issued to brand-new companies to run laboratories in the past two years?

Dr. Psutka: I would have to check that. I do not recall.

Miss Stephenson: One or two, perhaps?

Mr. LeNeveu: Yes. It is not my area, but I expect there probably not have been any.

Miss Stephenson: I believe there were not any.

Interjections.

Miss Stephenson: It has not been one of the areas in which new licences have been easily granted by the ministry. It is one of the things that does not happen.

Mr. Chairman: Perhaps you could include that with the other information, Dr. Psutka.

Mr. Wiseman: To be clear on how a lab is paid, was it 48 cents per unit?

Dr. Psutka: Per unit. For example, if a sugar test is six units, it is six times 48.

Mr. Wiseman: On page 6, you went on to say that at more than a certain number of tests, it starts at 100 per cent and then goes down to 50 per cent.

Dr. Psutka: That is based on a utilization factor.

Mr. Wiseman: How many of the ones that are functioning are functioning so they get 100 per cent and how many are down at 50 per cent? If the 50 per cent ones are just larger and really need to do these tests, is that not hurting them? I know you want to save money--

Dr. Psutka: I will defer that to Mr. LeNeveu, who negotiates on that tripartite committee.

Mr. LeNeveu: The simplest answer to your question is that the discount that applies to any company ranges from zero to whatever because it is hinged to one practitioner. The discount applies to a practitioner who has a lot of tests. The logic behind it is, for example, if you go to a doctor's office and pick up one sample, your costs are quite different from the cost from another doctor who always has a great number of samples and you pick up 10 or 12 samples because the vehicle--

Mr. Wiseman: We are just talking about physicians here then, not labs?

Mr. LeNeveu: Yes.

Mr. Wiseman: Not general labs?

Mr. LeNeveu: The simple answer to your question is that for any given company, the discount may be zero to about seven or eight per cent,

which I think was the highest at one point, on the total volume of work that particular company did through the laboratory licensing system.

Mr. Wiseman: You do not have any that are--

Mr. LeNeveu: None would be down at the percentage you are describing.

Mr. Wiseman: You mentioned that physicians are able to test for 13 different things in their own offices. You mentioned that a few of those are more serious or more involved than simple blood samples for diabetes or whatever. In a doctor's office--Bette could probably answer this too--who would be the qualified person in the office? Would a registered nurse be able to do that, or do you have to have a lab technician on your staff to carry out these tests?

Dr. Psutka: First, it could be anyone in a doctor's office. Doctors are not licensed; they do not have to have a lab licence to do these tests. Any physician can test his patients.

The 13 G codes represent 13 fairly simple tests such as the white count, haemoglobin or urinalysis. Those can be done pretty accurately by the office nurse or the physician. Technically speaking, the physician is responsible for the behaviour or the ability of his staff; therefore, I am sure he would be trying to maintain quality. However, the L codes represent more exotic tests. Some physicians, because of their training or interest, may be doing other tests. For example, somebody in endocrine diseases may want to do some specific tests, has spent the time, has a technician and his own equipment and is doing that in his office.

14:50

The black box I talked about is a whole new generation of equipment that is supposed to take the complications and difficulties out of lab testing. One has to understand that these are based mainly upon having chemical reagents packaged in such a way that somebody does not have to be pipetting and titrating. One takes a drop of blood or serum and applies it in a certain fashion to a package of chemicals, whether that be on a piece of paper or in a test tube with a prepackaged interreaction format. Then one sticks it into a machine, a black box that has a computer inside, and it gives a result.

The concern that is being expressed throughout medicine right now is exactly your concern: Who is doing it? Are the results accurate? In other words, if we are buying that test for the public, are we getting good results back?

Mr. Wiseman: They would not have the sophisticated equipment that one would have in a bigger lab. If someone diagnosed something there and started treating it, it might not be the proper treatment because of what he or she had to work with.

To go back to when I was in Health, I hope you do not have any chiropractors to whom you are giving the authority to do those 13 blood tests.

Dr. Psutka: As far as I know, chiropractors are not allowed to practise lab medicine. That is not to say--

Miss Stephenson: As far as you know, Dr. Psutka.

Mr. Wiseman: Yes; I like that. It was under the licensing inspection program. When you go around, do you make sure there are qualified people as well as the proper equipment to carry out these tests?

Dr. Psutka: That is correct.

Mr. Wiseman: I guess you partly answered that before.

On page 11 you mention that since 1974 the Ontario Medical Association has been asked to carry out inspections of labs that we have out there.

Dr. Psutka: It does not really inspect. I guess that is not the way to say it.

To explain: First of all, the laboratory proficiency testing program was a good idea, and it has taken since 1974 to come to the level we are at. Let us take the example of sugar testing. The lab proficiency testing program prepares testing samples, which are then sent out to every laboratory in the province that is participating in the program. The laboratories are asked to do readings on these samples and submit them back to the LPTP. They are then measured against the standard to see whether they are achieving accurate results.

Once the lab proficiency testing people have identified that a laboratory is having difficulties, they go through a very lengthy process of onsite visits. I guess one would have to use the word "inspections." We have experts, such as physicians and lab technology people, who go out and actually see how the lab functions, how the people work and who they are.

If they see that remedial work is needed, it is provided in two ways. There is a thing called an educational assistance program, where people go out and work with the technicians. Continuing education is also provided. The Toronto Institute of Medical Technology is involved in this area; it provides the educational program.

If a lab, after having gone through all this, is still unable to achieve accurate results, then it is reported to the conjoint committee of the ministry as being nonproficient and nonremedial. At this point the ministry inspects the laboratory and begins to work with the owners to see whether the problem can be alleviated. If not, the licence for that testing is removed from the lab.

Mr. Wiseman: Have you had many? You mentioned that most labs test 35 or 40, and then some have more sophisticated equipment and training, which puts them into the range of 200 or 300 tests or whatever you mentioned. Have you had many where you had to back them up to 40? I guess I am looking for the protection of the public and--

Dr. Psutka: So are we.

Mr. Wiseman: --how closely you inspect them and whether you do more than slap them on the wrist.

Dr. Psutka: As soon as the laboratory is reported as being nonproficient, we begin to insist first that they do not do the tests but that they do split testing. They send their tests off to proficient labs, and those are the results that go to the doctors. We, however, compare their tests with the other lab's, and that gives us an idea of whether they are improving.

Sometimes it is a matter of new equipment; sometimes it is a matter of technical changes, technicians or lab directors. There are all kinds of factors in why these things take place but, on the average, most laboratories are able to pull up their socks once they are identified. Some are not, however, and I could provide a list for you of labs that have been declared nonproficient.

By the way, in the case of a private lab where there is a medical director responsible, if a lab is declared nonproficient, it is also reported to the College of Physicians and Surgeons of Ontario so that the laboratory director, if he is a licensed physician, also has to answer to the college of physicians and surgeons about why his lab is not proficient.

Mr. Wiseman: It worries me. I have spent a lot of time in a lab giving blood samples and one thing and another. Is there any problem with cleanliness or anything? When they are taking one's blood, could he get any of these diseases that are floating around as a result of--

Miss Stephenson: Dirty needles?

Mr. Wiseman: Yes, dirty needles or whatever in a lab?

Miss Stephenson: Not in a lab.

Dr. Psutka: Not any more. I am not saying it could not happen, but most laboratories are very cautious of this area, obviously because of litigation, among other reasons. The point of the matter is that we are in an era of disposable equipment.

Mr. Wiseman: They dispose of the needle, but they do not dispose of the syringe.

Dr. Psutka: No. They use Vacutainers.

Mr. Wiseman: They use the vacuum thing again?

Dr. Psutka: No.

Miss Stephenson: They are disposable.

Mr. Wiseman: I watched the girl; she did not throw it away.

Dr. Psutka: As soon as the Vacutainer is punctured, it loses its vacuum. Therefore, they would have to take off the cork, clean out the thing and restore the vacuum.

Mr. Wiseman: She throws away the needle.

Dr. Psutka: They just would not do it. It is not worth while.

Miss Stephenson: They do not have that kind of equipment.

Mr. Chairman: They usually give it to the kids to play with.

Miss Stephenson: Oh no, they do not.

Mr. Wiseman: I would like to be darned sure that cleanliness is addressed.

Dr. Psutka: Seriously, in the two years that I have been responsible for the lab program, I have not come across any instance in which that has been a factor.

Mr. Chairman: Mr. Wiseman, I do not want to interrupt you, but I think we are getting a bit afield. Do you have further questions? I have a list.

Mr. Wiseman: No. I am fine.

Mr. Chairman: For the benefit of all, so you know where you are on the list, I have Mr. Sargent, Dr. Stephenson, Mr. Cooke, Mr. Polsinelli, Mr. Andrewes, Mr. Reyecraft and Mr. Johnston.

Mr. Baetz: You had me too.

Miss Stephenson: Do not forget Mr. Baetz.

Mr. Chairman: Mr. Baetz, I missed you.

Mr. Sargent: I recall in the happy days when we were in the opposition--

Mr. Wiseman: Would you like to go back?

Mr. Chairman: Is that your question?

Mr. Wiseman: We would like to see you there.

Mr. Chairman: Do you recall?

Mr. Sargent: I do recall. On the standing committee on public accounts, we had a circus for quite a while with these clinics, laboratories and whatever. I want to congratulate the doctor on what is pretty well an umbrella approach to this.

15:00

In this field, we are talking about \$500 million per year. It works out that every person will have at least eight tests per year, from the figures shown here.

Mr. Chairman: To correct you, it was \$528 million in 1984-85.

Dr. Psutka: There were 128 million test procedures, though, and he is dividing those by nine million.

Mr. Sargent: Yes, and that \$525 million is pretty close to half a billion.

Mr. Chairman: Continue.

Mr. Sargent: No wonder he is a judge.

Mr. Chairman: I want one thing cleared up: The legal profession is not under review here. That is for another day. Go ahead, Mr. Sargent.

Mr. Sargent: How prevalent are private laboratories? In the United States, what is the parallel? Are we in sync with what they are doing there?

Dr. Psutka: I would have to confirm the data, but I suggest there is probably more physicians' office testing going on, in as much as the black boxes have been available below the border for a couple of years. In Canada, they have to be cleared through the various licensings by the federal authorities to be allowed to be sold in Canada. There may be more private involvement in the US.

Another recent phenomenon is that, with the changing face of health care delivery in the US, the private sector is definitely becoming more involved in the hospital sector. One has to remember that the hospital sector down there is also private in most cases. It is very difficult to compare. I would have to say it is an apples-and-oranges comparison, but we could try to break it out somehow or other to give you those data.

Mr. D. S. Cooke: Can you do it on the number of tests?

Dr. Psutka: Yes. That can be found.

Mr. Sargent: Say that again; I missed that.

Mr. D. S. Cooke: I am wondering what the comparative data would be on the number of tests.

Dr. Psutka: If one goes to the literature, and I spent a fair amount of time reading literature in this area, everywhere I look, not only in North America but across any major country, the real issue is increased testing. It reflects many factors, which is what we listed on page 9. There is a definite increase in utilization. I think you would find that below the border, as here, there is a definite increase in this area.

Mr. Sargent: It is pretty big business then.

Dr. Psutka: Health care itself is big business.

Mr. Sargent: Yes, we know that. But there are 553 individual tests. Can each and every lab handle the whole range? They cannot. The specialists do only certain things. Is that correct?

Miss Stephenson: Are there any labs that do all 553?

Dr. Psutka: Some of the large corporations such as MDS would probably have most of the tests.

Miss Stephenson: Within, but not in one lab.

Dr. Psutka: Oh no, within their network.

Miss Stephenson: Yes.

Dr. Psutka: There are specialized labs. For example, there is a reference lab that comes to mind, located in London; it does many of the esoteric things, and that is all it does. It does not do the common tests.

The lab system itself has sort of shaken itself out. It is not worth doing some of these tests if you only do a small number, by the time you pay for the technician and the equipment. It is more frequent to send it out or to centralize your resources.

Mr. Sargent: Would you say about 90 per cent or 99 per cent of the investors and profits would be in the medical profession?

Mr. LeNeveu: No.

Mr. Sargent: Would they go to ordinary businessmen?

Mr. LeNeveu: I am just guessing, but in dollar terms, probably 25 per cent of the private laboratories are owned by doctors. The other laboratories would be owned by corporations. There may be doctors on the board of directors or they may have a partnership interest in the corporation, but the laboratories are not owned by doctors.

Mr. Sargent: So the corporation would be like a chemist or a manufacturer.

Mr. LeNeveu: It would be a private corporation specializing in the field.

Mr. Sargent: I do not understand that. If I was a bricklayer, could I open up a lab?

Mr. LeNeveu: Every laboratory will have a medical director. The ownership is not necessarily with the physician. MDS Corp. is a public corporation.

Mr. D. S. Cooke: If we break down the ownership of corporations versus physicans, to incorporate does not necessarily mean all that much. The corporations could still be 75 per cent owned by doctors.

Mr. LeNeveu: That is right. Unless you know who the share owners are, you cannot tell the distribution. Exclusively doctor-owned laboratories are about 25 per cent of the total or less, I believe.

Mr. Sargent: Of this \$500 million each year, you say the majority of that does not go to doctors?

Mr. LeNeveu: No. If you would look on table 4, in the back, it shows that of the \$500 million you are referring to, commercial laboratories account for \$207 million, hospitals receive more than \$300 million and public health laboratories receive about \$13 million. The private laboratories are a small percentage; 40-odd per cent of the total. That \$207 million would in turn break down between those laboratories owned exclusively by physicians as distinct from those laboratories owned by private corporations.

For instance, MDS, as one separate corporation, is more than 25 per cent of the \$207 million. It is by far the largest. The next largest corporation would be something in the order of 10 per cent of that total dollar value. It drops down very quickly, and MDS is two and a half or more times larger than any other corporation province-wide. It is a very big company. It is a public corporation.

Mr. Chairman: Who is MDS? What does it mean?

Miss Stephenson: Medical Diagnostic Services, is it not?

Mr. Sargent: Could I buy stock in that?

Mr. Chairman: We will adjourn for a few minutes, Mr. Sargent, so you can go out to buy some shares.

Mr. R. F. Johnston: Stick with Extendicare.

Mr. Chairman: Do you have any further questions, Mr. Sargent?

Mr. Sargent: Yes.

Miss Stephenson: Extendicare also has labs.

Mr. Sargent: It owns labs?

Miss Stephenson: Yes.

Mr. Sargent: It is for senior citizens.

Mr. D. S. Cooke: Is that a complete breakdown of the information? Can you give us a breakdown of ownership, with a breakdown of who does the majority of the lab tests?

Mr. LeNeveu: I am not sure whether there are any other public ones. There is Extendicare and MDS out of the large corporations. I am not sure whether any of the other ones are publicly held corporations as against private corporations.

Mr. Sargent: You say that if 100 corporations owned the majority, 70 per cent of the--

Mr. LeNeveu: The simple way of saying it is that of the \$207 million, there are 10 corporations which represent 70 per cent of that dollar value. Two of the larger ones are Extendicare and MDS.

Mr. Sargent: I think Bette Stephenson and company have a pretty tight ship there.

Miss Stephenson: I do not have a company, I am sorry. What are you talking about? You are talking about MDS, Extendicare and the other commercial laboratories, or the other 100 or whatever it is, having a percentage of 38.4 per cent of all the laboratory testing that is done in Ontario. Right?

Mr. Sargent: Is that the figure?

Miss Stephenson: Yes. Look on table 4. It shows that in 1984-85, the commercial laboratories were responsible for 38.4 per cent of all the laboratory testing that was done. Hospitals were responsible for 59 per cent and the public health laboratories were responsible for 2.6 per cent.

Mr. Sargent: Who sets the rates?

Mr. Chairman: I think that is contained in the material.

Dr. Psutka: Remember again that private labs are reimbursed using the LMS system, and that rate is determined through the tripartite negotiations among the Ontario Medical Association, the ministry and the Ontario lab owners.

Mr. Sargent: Say that again.

15:10

Dr. Psutka: The private laboratories are based upon a unit value called the IMS unit: labour, material and supplies. I think it is about 48 cents a unit right now. That unit is negotiated annually by a tripartite negotiation team of the ministry, the lab owners of Ontario and the OMA section of laboratory medicine.

Mr. Andrewes: Who assigns the unit value to these procedures?

Miss Stephenson: It is tripartite.

Mr. LeNeveu: It is tripartite. The new values were assigned back in 1974. When the negotiation goes on, the first negotiation deals with any change in weights. I have been involved in those negotiations over the past seven years and I doubt that in any given year we change more than one or two weights. Once the weights are settled, the negotiation starts on the change in the unit value. In the past five or six years, the rate has been going up at about 50 per cent to 60 per cent of the rate of inflation because there has been a growth in volume. There is also the advantage that comes from mechanized tests, so that the costs do not go up proportionately to inflation.

Mr. Sargent: One more question. This is not a closed shop?

Dr. Psutka: What is your definition of a closed shop?

Mr. Sargent: It is pretty well within the medical field.

Dr. Psutka: In the past, most labs were held by physicians, but that has seen a great shaking out. As we have said, I am guessing, but about 25 per cent or 30 per cent now are physician-owned. That is a very small number when you look at the total volume. By the way, physicians who own labs are not allowed to test or refer their own patients.

Mr. Chairman: Has the black box shaken these physicians out of the lab field so that they now do the tests in their offices?

Dr. Psutka: No, the black box might see more physicians getting back into lab testing as it becomes simple to do.

Mr. Chairman: Within their offices.

Dr. Psutka: Yes.

Miss Stephenson: One of the interesting questions I think you might try to determine the answer to is the significant rate of decline in the execution of laboratory tests by physicians in their offices, compared to the increases of laboratory testing in the field.

It is my understanding that there has been a fairly significant decline in individual physician laboratory testing and that most of the testing that was done by physicians in offices back in the days when I was in practice is now done in laboratories rather than in the office. The overall increase has been extremely significant in terms of the number of tests per patients per year. Is that true?

Dr. Psutka: Yes.

Miss Stephenson: You have listed what you consider to be the factors involved in this. There is one you have very politely tended to ignore, and that is the element of medical teaching that persuades students that it is wiser to depend on the laboratory than on their brains.

Dr. Psutka: I do not know whether I ignored it, but if I gave you the paragraphs to explain each of these factors, I think you would find it.

Miss Stephenson: I might find it in there?

Dr. Psutka: Yes. That may be under "changes in preference."

Miss Stephenson: It is a weird kind of title for that, but there most certainly has been in the past 30 years a very significant change in attitude on the part of physicians, particularly physician-teachers. It is said that every patient who is admitted to one of the teaching hospitals is tested for absolutely everything, including the serum rhubarb. In fact, one of the difficulties faced by patients admitted to teaching hospitals is the great risk of dying of investigation.

This attitudinal problem is a part of the sociological development, particularly within North America, which tries to persuade all its citizens that life should be discomfort-free, pain-free, totally happy and without any kind of discombobulation at any time. If there is not that kind of atmosphere, there has to be a pill or a circumstance that will change the situation.

Mr. Chairman: It is called hedonism.

Miss Stephenson: That is not really hedonistic. I believe it is an absolutely idiotic degree of optimism which can never be achieved within the human condition. The other factor, of course, is litigation. The degree of concern about litigation which is prevalent within the minds of all physicians is just overwhelming. Every physician is terrified of not having done a test and having someone take him or her to court and ask, "How could you possibly have missed this diagnosis when this test was available to you?"

Therefore--and it appalls me to say this--I find young physicians who see, on every occasion, every patient--the patient they may have seen just three months before--running the full gamut of 60 biochemical tests at the next visit, which is a monumental waste of money. They tell me that is the only way they can practise with comfort in this day and age, because they know they will at least have their behinds covered if someone accuses them of missing anything.

Exactly the same thing is happening with X-rays. They are X-raying everything in sight. This too is not only expensive, it is also dangerous. The laboratory testing is particularly dangerous when the tests come back with slightly false results which are borderline and people are treated for diseases they do not have.

Mr. D. S. Cooke: When it is all over, they write a prescription.

Miss Stephenson: No, they do not write a prescription. When it is all over, unfortunately you pay for it, I pay for it and everybody else pays for it. It seems to me it does not matter whether it is the private sector, the public sector or anybody else involved. Until we change the public attitude about what you can do for your dollar, we are not going to get anywhere.

Mr. Chairman: Does the witness agree with the statement that has been made?

Dr. Psutka: Some of it.

Miss Stephenson: I would be astonished if Dr. Psutka agreed with all of it.

Mr. Chairman: I wanted to be sure that Dr. Stephenson was identified as being a member of the (inaudible) witness.

Dr. Psutka: The major problem facing health care delivery right now in laboratories is utilization. I would suggest there are many factors that drive up utilization, including those that Dr. Stephenson has mentioned.

The health service patterns committee that we mentioned in the report went to a major teaching centre in this province and this teaching centre had been developing a thing called CMGs--case mix groupings--which was a Canadian variation of DRGs, which is the American diagnostic related groupings. In the United States, they have looked at patients and they have analysed--for example, a 20-year-old male with an appendix should be in the hospital for X number of days, should have the following tests done, it is probably worth \$400 a day and that is what they pay the hospital.

Here in Ontario, there has been a project to look at this and to include in that an element of severity, because the American codification did not entail severity and therefore it had some problems. We very expectantly went to this major teaching centre to see the results of their first 50 CMG codings. We were expecting, since it is a teaching hospital, that we would see a pattern of practice that could be illustrated by data.

When we got there, we found that in the laboratory section, which is the only area we looked at, the computer could not compute a pattern of practice because there was not any. What we had here was an absolute ad hoc approach to health care in these 50 codes. We felt that needed to be explored. We are no longer meeting in this project, so I can only tell you that part of the story.

Mr. Chairman: Would that have provided a method to overcome the litigious problems that Dr. Stephenson suggests?

Dr. Psutka: It would definitely help. What we need is a very intensive approach to utilization at the school-university-medical school level. One of the problems facing all of us who provide health care in the province is that we have very poor management information systems available to us right now and therefore we do not have easy ways of getting at what we are doing and beginning to explore whether we can do it better or more efficiently. This, of course, leads into the litigation and paranoia that Dr. Stephenson has suggested. There is a lot of ass-covering out there by physicians; there is no denying it.

Mr. Chairman: I think she said "behind-covering."

Dr. Psutka: Which might actually reflect Dr. Stephenson's--

Miss Stephenson: It depends on your--

Dr. Psutka: You and I were talking earlier about an oversupply of lawyers, but anyway it is true.

15:20

Miss Stephenson: Particularly the Melvin Belli variety who arrive in Canada to tell lawyers that there is nothing wrong with awarding monumental sums of money and that the contingency fee concept is exactly right.

Mr. Chairman: Melvin has done very well on that philosophy.

Miss Stephenson: Indeed, yes. I am sure he could make millions in Ontario.

The questions that need to be raised have been raised by Dr. Psutka. As he said, we do not have the answers to them at the moment and I am not prepared to ask a further question for which I know we do not have the answer at this point.

Mr. D. S. Cooke: Are there any restrictions at all on ownership?

Dr. Psutka: I would have to check that. I am sure there are some but I do not want to answer the question without doublechecking.

Mr. D. S. Cooke: If one company or individual is purchasing another company or an individually owned lab, is there any process that has to be gone through for approvals from the ministry?

Dr. Psutka: They go through the public interest evaluation that is in appendix B. At that time, we review our records and the history and the background. We look for things such as efficiency, ownership, who the director is and whether it is in the public interest for that lab to be relocated, because they are often bought for relocation. There is a great shuffle of licences at times but one can see that most of the shuffling goes on at the bleeding stations.

Mr. Chairman: Are the licences transferred in those circumstances or are they cancelled and new ones issued?

Dr. Psutka: Sometimes they transfer to a new location and at other times they assume the location. Interesting phenomena take place. For example, a company might actually buy the building to get the other guy out of the building.

Mr. Chairman: My point is, does the licence then become an asset in terms of the sale?

Dr. Psutka: I suggest the licences are assets at this time.

Mr. D. S. Cooke: Since there has been all this consolidation over the past decade, have there been any refusals?

Dr. Psutka: Yes.

Mr. D. S. Cooke: Can you give us that information?

Dr. Psutka: As long as it is not something that has to be held in confidence.

Mr. D. S. Cooke: Even if there are matters that have to be held in confidence, perhaps there are numbers so that we can have an idea as to how many have been rejected.

Miss Stephenson: General reasons rather than specific reasons.

Mr. D. S. Cooke: Have any studies been done by the ministry to determine which labs are most efficient, the hospital labs versus the public labs?

Dr. Psutka: Efficient in what way?

Mr. D. S. Cooke: Over the past couple of years I have received letters from a hospital in Kingston as well as from one in Sault Ste. Marie, and there might be others, that make the point that for a relatively small increase in their global budget they could do this many more tests, which would be less because they are not on fee for service. Are you aware of any analysis of that by the ministry?

Dr. Psutka: It is hard to answer. The private laboratories per test probably operate on a less costly basis than the hospitals. The private laboratories are faced with taxes, purchases of equipment and so forth, whereas hospitals do not have those costs. On the other hand, hospitals are providing 24-hour coverage, and the private laboratories are designed to operate during the week during working hours. It is difficult to do comparisons. There have been attempts to do that, but it is my impression, without seeing good studies, that on a per test basis the private sector does a better job.

When you look at the private sector tests, they not only do the test but also go out into the community to pick up the test and bring the results back. A number of years ago there was an experiment where the ministry tried to help a number of hospitals do community testing. When the sample was in the hospital they could do the test, but they had problems with the community delivery service element because in a sense they were in a new business; their business was taking care of patients in hospitals. They tried to run another business, which was a different business, on the side, if you like, and they had some problems with it in terms of delivery and satisfaction, primarily for the general practitioners who were served by that experiment.

On the other hand, as has been mentioned, in Hamilton hospitals have played the role for many years and they have developed that expertise. It is very hard to crosswalk. You are comparing the cost of services in a hospital 24 hours a day, up and down among the wards, versus the private sector, including transportation back and forth and working in a smaller-hour time frame.

Mr. D. S. Cooke: Do you have any figures on the profit levels of the private labs?

Mr. LeNeveu: MDS information would be available because it is a public corporation. Extendicare is also a public corporation, but I do not believe it breaks out its--

Mr. D. S. Cooke: The problem with looking at some of those, though, is that they are into so many other things.

Mr. LeNeveu: The answer is that, other than MDS, we do not.

Mr. R.-F. Johnston: Separate it out from the oil interests.

Mr. LeNeveu: MDS is into some other lines as well. It is primarily a laboratory company but it does--

Miss Stephenson: It started as a laboratory company.

Mr. LeNeveu: From its public documents you cannot isolate the proportion of profit that comes from lab operations.

Mr. D. S. Cooke: What happens in a community where a physician owns the lab or a group of physicians own the lab and they run their own private practices? Is there not an obvious conflict of interest where they are going to use their own labs rather than hospital labs?

Mr. LeNeveu: They are not allowed to.

Mr. D. S. Cooke: Was that the restriction in the 1970s?

Mr. LeNeveu: Yes.

Miss Stephenson: There are some exceptions to that. For example, some of the endocrinologists who do very specialized tests that nobody else does, because they see the patients as well, are permitted to do that. However, if you are an ordinary practising physician and you have an interest in a laboratory, you are not supposed to refer your patient to that laboratory; you are supposed to use another laboratory for that.

Mr. LeNeveu: It is a conflict of interest.

Mr. D. S. Cooke: I have never had any hard evidence, but I have heard people talk about labs that also own medical office buildings. If doctors use those particular labs, then there is a break for them for their office rental. Have there ever been any complaints such as that or investigations you are aware of that have proved--

Dr. Psutka: There have been complaints, and there has been some court activity in this area, but the last one that comes to mind was not found against the company. The physicians were shown in court to be practising medicine and, basically speaking, were doing what they were allowed to do. It is an area where there is a lot of talk, but again it is difficult to show.

Mr. D. S. Cooke: If you go to see a physician and the physician refers you for some test, and then you come back to the physician to be told what the test showed, there are three charges which are all under fee for service. Besides the philosophy of doctors trying to protect themselves legally, is there not a real financial incentive? Is not one of the basic problems of fee for service that using these kinds of services is a good reason for a recall, so you get paid twice?

Dr. Psutka: That is a difficult one to answer. Simplistically looked at, I would say fee for service is driving that, but if the physician does not have ownership of the lab and is not getting any money back from it, then he is not using the lab for that reason. Sending the patient out for testing and then having him back to review the results of the test is where we are at this point. As I stated in the paper, if black-box technology does come down the pipe, one would have to factor in that it would be a one-visit trip. Therefore, in the long run those tests actually may be less expensive to the health care delivery system than the format we have now.

Mr. D. S. Cooke: On the other hand, we could have more tests done.

Miss Stephenson: That is right.

Dr. Psutka: Again, it depends on the value of the tests. For example, the machines on the market now do about 20 tests. The reagent papers and strips run between \$1.75 and \$2 to \$2.50. As I said earlier, glucose is six times 48 cents. If the machine costs \$10,000 and you are going to amortize it over four or five years plus the cost of the reagent, there is some small profit that would have to be watched and observed to make sure it was not being milked.

Mr. D. S. Cooke: In Ontario, we do not have the data to really determine the efficiency or usefulness of some of these tests.

Dr. Psutka: No, not now. We would have to factor into that scenario the fact that the patient is off work for half a day. What does that do to the common good of the province when there is all that lost work, etc.? There are so many things. When one gets into health economics, it is easy to look at it simplistically, but in the total picture it is a very difficult thing to quantify.

15:30

Mr. D. S. Cooke: Are there any plans on the part of the ministry to try to develop some of the data collection so that proper analysis of this \$500-million expenditure can be properly analysed?

Dr. Psutka: Yes. I am going to speak a bit about that when I get into the emergency health side of things, because there is a project going on there. On the other hand, I can tell you now that most of our major hospitals are in the process of developing management information systems. Feedback loops from the laboratory to the floor are a part of those systems, and physicians will definitely be involved in those types of audits and evaluations.

I can see computers within a few years--in fact, it is happening below the border now. If I am not mistaken, one of the computers now going in in London, Ontario, is word-friendly. It has a vocabulary of 2,000 words and you can order lab tests verbally, but the computer also will not allow you to order those tests if they have been ordered within a certain time frame or if you are duplicating. For example, there are two tests to check kidney function that are very commonly used, the blood urea nitrogen and the serum Creatinine; if you order both of them, the machine will let you have only one.

Mr. Chairman: It sounds like the money machine.

Dr. Psutka: It could be a money machine, but if it is used appropriately--in the American situation, where the hospitals have become more accountable for what is happening because of diagnosis-related groupings, extensive feedback groups have been developed between laboratory physicians and the departments. Some of our major teaching hospitals in Toronto are decentralizing their budget codes so that each teaching department or ward is responsible for what is done on that floor and they are going to become very interested in the bottom lines.

Mr. D. S. Cooke: The difficulty with building some of this accountability into the system will be if people do not go to the same physicians all the time.

Dr. Psutka: That is a real problem. One of the things we have facing us, and not only with lab medicine, is that, to my knowledge, in the past

couple of years there have been at least four inquests in the Metro area alone on lack of communications among physicians, hospitals and labs. People have died waiting for test results or they just were not collaborated, and that is a problem.

Mr. D. S. Cooke: Has there been any type of analysis for lab use or any other type of X-ray and that type of thing for health service organizations and community health centres versus private fee for service?

Dr. Psutka: No. If you are talking about CHCs and HSOs as being an Ontario phenomenon, I do not think there is very much to report. There are an awful lot of studies below the border with preferred provider organizations and health maintenance organizations. Basically speaking, the PPO and HMO phenomenon below the border causes people to analyse how they practise; therefore, one would see improved rates and utilization. The sawoff point is, when does one become accountable for health care and when does one become accountable for dollars spent?

What is happening below the border and what is just starting to happen here is that the medical profession, because of these different factors, is beginning to establish standards of practice that have to be met. There is always a reticence to do this, again because of the medical-legal aspect of things, and there is always a bit of fear in that area, but I think it can be done without having problems. In the long run, it will probably put the quality of health care delivery at a higher level.

Mr. D. S. Cooke: For some of the professions, dentists in particular, private insurance companies that provide dental services are looking at some of the models used in the United States. I gather that London Life and perhaps one other company is looking at saying to the people they insure, "If you are going to go to a dentist and you are insured by us, you have to stay with the same dentist for a certain time."

Dr. Psutka: Again that is a different phenomenon. Dentistry is not an insured benefit here.

Mr. D. S. Cooke: No, but it allows you to build in some of the accountability.

Dr. Psutka: Exactly. If you go below the border again and you belong to an HMO, when you buy into an HMO, as a consumer you are aware of what it is offering. For it to offer and compete against other HMOs, it has to become a lot more aware of what it is doing. Therefore, it sits down and spends more time debating its approach to health care delivery.

Mr. Chairman: Is there anyone here who does not know what an HMO is?

Dr. Psutka: An HMO is a health maintenance organization. It is another approach to health care delivery. There was an article in the Toronto Star a couple of weeks ago about one in Rochester that has 180,000 people enrolled. Various companies buy into them, and people can buy into them privately. They guarantee a level of health care for a certain fee every year. Therefore, they have to operate within those set budgets. They do not have a limitless availability of funds.

It is projected that by 1990 about 40 per cent of the population of the United States will be covered under one form of HMO or another. It is projected, however, that 40 per cent of the population will be covered by 20

per cent of the physicians by 1990, because HMOs practise in a different format and therefore they are not only parsimonious as far as testing and drugs are concerned but also as to physicians.

Again, one can debate at great length about HMOs, and I do not know if that is coming up under something else--

Mr. Chairman: Can you equate that to an HSO, which is what Ontario has been--

Mr. LeNeveu: Same thing.

Mr. Chairman: Well, it not quite as private--

Miss Stephenson: Same concept.

Mr. Polsinelli: I am sure I appreciate your explanation. I am sure the chairman also appreciates it. However, my question was referring to your infamous page 8 again, where you clearly indicate that the private sector market share has increased in the past six or seven years and that the public sector market share, which I guess would be the public health laboratories and the hospital sector, has decreased.

My concern is that, as I know has been stated previously, 10 of the largest corporations in your evidence control 61 per cent of the private sector, which has gone up to 69 per cent. That is more than 20 per cent of the total market share and rising. I wonder whether your ministry has a policy, stated or unstated, with respect to either increasing or decreasing the public sector market share.

Dr. Psutka: No, there is none.

Mr. Polsinelli: I take it then that you are approaching it on an ad hoc basis. I guess Mr. Cooke's question earlier was leading along the line of determining whether it was more efficient from a cost point of view for the government to fund public sector organizations such as public health laboratories or hospitals, rather than the private sector, in terms of performing the tests. Would you not agree that is an analysis that is needed in terms of whether we are getting the biggest bang for the buck?

Dr. Psutka: There needs to be an analysis applied to see which is the most efficient way to provide a declared benefit to the people of the province. But to compare each of these sectors is very difficult. The public health sector, for example, is government funded, with no taxes. One would have to factor in a lot of things. We have tried to do that, by the way, and we have shown that the public health labs do a very efficient job. But again, if one got into a statistical argument with an economist, the economist would probably be able to tear holes in the argument.

I think the public health labs do a remarkably fine job, but they are very specific in what they do. In other words, they are reference centres for very esoteric tests that probably need to be done in a reference centre. For example, they do the venereal disease testing for the province as well as the hepatitis and acquired immune deficiency syndrome testing; basically speaking, fungus tests and parasitology. These are areas in which we have had to develop expertise. Rather than licensing a multitude of facilities to do some of these things, it has been better to maintain those as core tests, and we get much better, accurate results.

Mr. Polsinelli: Surely within the hospital sector you must be able to provide the full range of laboratory services.

Dr. Psutka: You could, but not every hospital in the province could provide that. Remember, what you are talking about is human expertise. I think Mr. Weisz mentioned that he is very concerned about the quality of results. Because of LPIT and the government's attention in parasitology, for example, we now have a world-class parasitology reporting program, but it would not be world-class if it were out there in 60 or 70 hospitals.

Mr. Polsinelli: If you were to change your system of funding the hospitals in terms of laboratory services from a global basis to a fee-for-service basis, how would their budgets change generally? Would you be able to give me a guesstimate of that? Would they increase, decrease or more or less be the same?

Mr. LeNeveu: If we went back to a fee-for-service basis in the hospitals, the laboratory service would probably start to expand and operate more in the hospitals than in the past.

Mr. Polsinelli: If you went back to a fee-for-service basis in the hospitals, you would guess the hospitals would start providing a greater range of laboratory services?

Mr. LeNeveu: At the moment the hospitals provide service for their inpatients and for their outpatients. The private community laboratories are providing services for the patients of practitioners in their offices. I suspect what might happen is that hospitals would provide more tests for inpatients than for outpatients. It would not necessarily result in a diminishing of the volume increase that is going on in terms of services for patients in community offices.

Mr. Polsinelli: The other point I would like to cover is that we talked earlier about the conflict-of-interest situation where a doctor has an interest in a lab and at the same time is referring patients, and it was clearly indicated that if a doctor has an interest in a lab, he cannot refer his patients to that lab. How do you define interest? Is one share in a public corporation an interest?

Dr. Psutka: No; it is if he is the owner and the licence holder.

Mr. Polsinelli: If he is the owner and the licence holder?

Dr. Psutka: If he is going to gain any profit from increased utilization of that laboratory, that would be a conflict.

Mr. Polsinelli: But if the doctor had, say, 10 per cent of a public corporation that owned that lab, would that be an interest? First of all, where does that come from? Is it part of a legislative package? Is that restriction a guideline by the OMA?

Miss Stephenson: It is only ethical.

Dr. Psutka: It is ethics.

Mr. Polsinelli: Then is it part of the OMA?

Miss Stephenson: It is part of the Canadian Medical Association code of ethics.

Mr. Polsinelli: I take it then it is not defined. It just says, "where a doctor has an interest."

Dr. Psutka: I would prefer to come back to committee with the exact background on your question, because it happened before I took responsibility for this division. I recall that as a practising physician I was aware of it, but I would have to go back and check into that.

Mr. Polsinelli: My last point is with respect to--

Mr. Sargent: Could you finalize that point? I would like to hear it.

Mr. Polsinelli: He is going to come back to it.

Dr. Psutka: We will supply you with the conflict-of-interest definitions by the college of physicians and surgeons.

Mr. Sargent: Could Bette--could she have stock in a lab and--

Mr. Chairman: Who is "she"?

Mr. Sargent: I said "Bette." Could she--

Interjection: You bet.

Mr. Polsinelli: It has not been answered. They are going to be providing that.

Mr. Sargent: Make sure she does not then.

Miss Stephenson: It is true that I could purchase stock in Extencicare or MDS, public corporations, as any other individual could; that would not be considered a conflict of interest, I believe.

Mr. Chairman: Even as a minister?

Miss Stephenson: As a minister, I do not think I could do anything. As a minister, absolutely everything is a conflict of interest.

Mr. Polsinelli: That is Dr. Stephenson's opinion of it, but I would like to see more information following up on that a bit.

One other question--as I indicated earlier, it is my final question--deals with the relationship that individual doctors would have with individual private laboratories. Based on the ministry's information, how would a particular doctor choose to use a particular laboratory? I can understand that a doctor would be concerned about efficiency and speed of service, but are you aware of any mechanisms whereby one laboratory could entice a doctor to use that laboratory rather than another?

Dr. Psutka: It is usually a very simple method, and the method is based on access. For example, a physician may move into a building where there happens to be a bleeding station run by XY Labs in the basement; so he would send his patients down there. Occasionally, a group of doctors may get together to put up a medical clinic and may be approached by a lab that has a licence that it wants to move, and it may rent space from those physicians. There may be some competition between various lab firms to gain that space.

Mr. Polsinelli: That is interesting. If a particular lab firm purchased space in a building that was owned by a group of doctors practising in that building, would there not be at least a perception of a conflict?

Dr. Psutka: They are paying rent.

Mr. Polsinelli: But that rent could be inflated. What competition-- if you have three competing lab firms--

Dr. Psutka: For a lab to locate in a building, either as a laboratory or as a bleeding station, it has to be licensed. Therefore, the competition has to do with whether it has a licence. It then has to go through public interest evaluation, which is outlined in appendix B.

Mr. Polsinelli: That takes me away from the point. It is not whether each one of these three could obtain the licence; I am saying, in terms of the conflict-of-interest provisions we were talking about earlier, if three competing lab firms could conceivably be granted a licence in that building, what would separate one from the other? Would it not be who pays the highest rent, percentage of profits perhaps, or other such factors?

Dr. Psutka: That is something between the lab people and the physicians. I am not in that area; I would not be looking at what rent each of them paid. We apply our public interest evaluation criterion rather stringently. If the lab owners are going to be making a presentation, I am sure they will probably tell you of some very bizarre ministry dealings, but we are just following the rules. From their point of view, one would expect that we are applying them in a funny manner, but we are not; we are very consistent in how we apply them.

Mr. Polsinelli: Would it be fair to say that the ministry is not particularly concerned about those aspects, but rather leaves it to the OMA to ensure that the profession is governed?

Dr. Psutka: Actually, it is the college that has to deal with those types of alluded-to dealings.

Mr. Polsinelli: Thank you.

Mr. Andrewes: I thought Mr. Polsinelli was going to ask my question. But back to page 8--

Mr. Polsinelli: I left one for you, Phil.

Mr. Andrewes: Page 9, dealing with the health services pattern project, illustrates the trends towards greater utilization. I wonder if there might be some explanation for the trend towards a greater private sector market share.

Dr. Psutka: Let me see if I can find the explanatory paragraph, which I thought I brought with me. Which page are you pointing out?

Mr. Andrewes: I am pointing out page 8.

Dr. Psutka: Page 9.

Mr. Andrewes: Page 9 explains the increase in utilization. I am looking at page 8, where you have said the private sector's relative market

share has increased from almost 29 per cent to 38 per cent. I think that in itself needs some explanation other than utilization.

Dr. Psutka: The most obvious one that comes to mind is purely accessibility, and I am speaking from my own personal experience as a physician. When a laboratory came to my small town of 15,000 people, suddenly I had accessible to me tests on which I could get results back within 24 hours. So I was more prone to utilize them, rather than going by the seat of my pants. As far as I was concerned, it improved my ability to diagnose. I would suggest that a laboratory just being physically present or accessible is going to increase utilization. There is no denying that.

15:50

Mr. Andrewes: Are you saying they fill the gap the public laboratories were not able to fill?

Dr. Psutka: Going back to the late 1960s, at the time to which this paper alluded, people began to get worried about laboratories and a lot of legislation was passed. In the small town where I was practising, the only laboratory I had accessible to me was at the local small hospital. It could do some tests but it was very busy doing testings for inpatients. The other testing I had available was the public health laboratories. I could use the mail-in canisters which often resulted in a 10-day or 12-day turnaround time.

Miss Stephenson: For blood sugars.

Dr. Psutka: That is right.

Mr. Sargent: It would take 10 or 12 days?

Dr. Psutka: Oh yes. It was mailed in and mailed back. That was in the late 1960s or early 1970s. In fact, our public health labs to this day still do blood sugars through a mail-in system.

Mr. Chairman: I thought that was in Europe or something.

Dr. Psutka: That is right. That put me in a very difficult position. I did some of the tests in my office but I did not have the sophistication to get into the equipment side of things, nor did I want to. Then the Hamilton-Wentworth hospital system I mentioned came to us in an outreach program and said it would do the testing as long as I drew the blood. They gave me all the canisters and all that. They offered a 24-hour turnaround time, which made the practice of medicine a lot more meaningful in my town.

Miss Stephenson: It certainly made caring for diabetics a lot easier, because it was horrendous.

Mr. Sargent: Will this black box help that?

Mr. Chairman: Just a second, Eddie, I do not think that is a supplementary.

Mr. Sargent: Sorry. It was not very intelligent, anyway.

Mr. Chairman: I would say you are a gentleman, Eddie.

Mr. Andrewes: On page 10, the third paragraph, on private sector

interests in hospital services, the suggestion here is that a number of private sector laboratory services are prepared to do certain work, such as pre-op work, for hospitals. Whose decision would it be to move in that direction?

Dr. Psutka: There are two things to point out here. First, although I may be corrected, I think it is Extendicare right now which operates the laboratory for the orthopaedic hospital, because the orthopaedic hospital has decided it is more efficient to contract that service out in the wake of--

Mr. Andrewes: Would it be the hospital board that would make that decision?

Dr. Psutka: Yes. The second consideration is about pre-surgery and pre-admission laboratory work. The issue is that the hospital has been funded to do work on inpatients. But there are people being seen in physicians' offices, not as inpatients, so the laboratories would do that billing through OHIP on a fee-for-service basis. The dilemma is whether moving what normally would be done in a publicly funded hospital out into the private sector is good or bad. That has to be debated.

Mr. Andrewes: It is not as simple as the hospital board deciding it will give a portion of its laboratory work to a private sector organization?

Dr. Psutka: If they do that, the billings cannot be to OHIP. They are already funded. According to the ministry's policies, they would not be funded to do that and therefore that would not be allowable. You may want to comment on that.

Mr. Andrewes: So the private sector would have to build a hospital and the hospital would reimburse them out of its global budget. Is that the way the orthopaedic hospital is operating here?

Mr. LeNeveu: Currently they pay out of their global budget for their services, yes.

16:00

Mr. Chairman: Before you go on, I have three more speakers: Mr. Reycraft, Mr. Johnston and Mr. Bates. As a housekeeping item, we have one more presentation and it was Dr. Psutka's rather naïve desire, with all due respect, that we would get through that one as well. Can we agree that we will sit until five, or does the committee wish to sit until 4:30? What is the wish of the committee? It has some bearing on questions that might be asked on the second presentation as well.

Mr. LeNeveu: We have about a dozen presentations for tomorrow, within the time the committee gave us.

Mr. Chairman: We do not want to back up. That is part of the problem. What is the wish of the committee--five o'clock?

Mr. D. S. Cooke: What we should do is restrict the questions to asking for information, since I know we are going to have further discussions over the next number of years with these gentlemen.

Mr. Chairman: I did not want to limit the questions. As Dr. Psutka said, it is an area in which there are a lot of questions requiring a lot of

answers. Is five o'clock acceptable to the committee? Hearing no negative comments, I will assume that five o'clock is appropriate.

Mr. Reycraft: After last summer on the standing committee on social development, five or 5:30 sounds like a very early adjournment hour.

Mr. Chairman: We do not want to let this committee get out of control, as that one did.

Mr. R. F. Johnston: Let us hope there is more competent chairing this time.

Mr. Reycraft: I thought the chairman would want to interject something.

I understand we are going to get additional information about the conflict-of-interest situation between physicians and laboratories, but I have a specific interest in where there is an accommodation contract of some kind between a physician and a laboratory. I am interested in knowing whether that would be perceived as a conflict. Would a physician who had an accommodation contract with a laboratory be able to refer patients to it? Would there be any restrictions on the kind of contract and how the charges for accommodation would be determined, etc.? I assume that could be provided along with the other information we have been told we will receive.

Mr. Chairman: That could be the start of a new committee.

Miss Stephenson: What is an accommodation contract? What are you talking about?

Mr. Chairman: They lease the building.

Mr. Reycraft: It is where a doctor owns the clinic and a lab is located within the same clinic. I assume there must be some kind of contract between the physician and the people who are operating the lab.

Miss Stephenson: A lease, yes.

Mr. Chairman: Does that answer your question Mr. Reycraft?

Mr. Reycraft: It answers one of them. I have another question. I have read what has been put before us about how the fee schedule is determined. Are any comparisons made with fee schedules in other provinces? Could you give us some idea of how the Ontario fees compare to those?

Mr. LeNeveu: The fees in Ontario are probably relatively competitive with other provinces. I know they are lower than the fees in Alberta, but honestly I have not compared them with other provinces. Many other provinces do not have a private laboratory system to the same degree Ontario does. For instance, Quebec often operates and serves its communities through extensions of the hospital system. I could try and get an analysis for you.

It is difficult to make comparisons with the American system, for a number of reasons. We have tried in the past and it is very difficult to make comparisons of fees. They vary quite a bit from one jurisdiction to another. They will be high in one fee and low in another fee and it is hard to evaluate the overall situation. There is no trend in it and that is one of the complexities of the analysis; 500 fees varying both ways in comparing one jurisdiction to another.

Mr. Reyecraft: I have one further question. It concerns statements made on page 11 about complaints from the general public. I would like to get some sense of the volume of those kinds of complaints and to know whether there is any particular pattern of the type of complaint that is received.

Dr. Psutka: For example, we had a complaint just recently: "I went to the laboratory, which was supposed to be open, and there was a 'Closed' sign on the door. Mr. Minister, why are you giving licences to people who do not open their facilities when I am there?" We then had to go and determine whether there really was a licensed facility there. We found in this case that there were supposed to be two people there. One person had been ill and the other person had to go to the washroom and she had locked the door.

There are frivolous complaints and there are substantial complaints. The substantial complaints would be, for example, those from other people that somebody had opened a laboratory and did not have a licence, and yes, that was true. There is a range of complaints.

Mr. Sargent: You cannot franchise them. You are going to sell them?

Dr. Psutka: You mean franchise the lab?

Mr. Sargent: Yes.

Dr. Psutka: They are not a franchise operation at this time.

Mr. R. F. Johnston: Hopalong Cassidy Labs, for example?

Mr. Reyecraft: Mr. Chairman, would it not be possible for us to get information from the laboratory inspection service that would indicate the number of nonfrivolous complaints that had been substantiated?

Dr. Psutka: No problem. We will give you a list of complaints that we have dealt with in the last year.

Mr. Reyecraft: I am not interested in knowing about the frivolous ones that Dr. Psutka has described. I am trying to get a handle on the degree of satisfaction or dissatisfaction that there is with the laboratories, and I would assume that the complaints and investigations of those complaints would be one measure of that.

Mr. Chairman: Just to follow up on your comment about the experience of Quebec, they do it all through hospitals. Are there any figures about their costs versus their population vis-à-vis our costs with private and public? Maybe we could get those figures, if that is possible.

Mr. LeNeveu: I doubt it would be possible. It would be a very difficult analysis to do. We would have some sense of what their local hospital budgets were, but a special analysis would have to be done by Quebec. We could give you our costs, but I am not sure about Quebec.

Mr. Chairman: If we could get a ball-park examination of those two aspects, it would be helpful.

Mr. Johnston, I cut you off. I did not mean to do so.

Mr. R. F. Johnston: I forgive you.

Mr. Chairman: Thank you very much.

Mr. R. F. Johnston: You have been a very generous chairman; there are very few of them. Speaking of parasitology, I have intimate knowledge of this now.

I have no further questions. Most of the things I wanted to know have already been asked, and I agree with Mr. Cooke that we should primarily try to get extra information at this stage. My interest was piqued by the comment that Quebec uses only an extension of the hospital system. Therefore, I wonder whether one thing we might try to accomplish, either through our research or through the ministry, if it has this easily accessible, would be some kind of comparative analysis of the various approaches to lab work that exist across the country, following from what Mr. Reycraft was saying.

Mr. Chairman: Just across the country? You do not want to go farther afield?

Mr. R. F. Johnston: Not at this stage; we should save that for a later date. But at this stage it would be interesting to know how we operate within the country. It sounds as though there is a fair range of possibilities, and perhaps that reflects lack of sophistication in some areas, compared with the Toronto teaching hospitals and that kind of thing. I would be interested in seeing it.

Mr. Chairman: It might also be helpful, along with that, if you are going to do it across the country, to have a breakdown of the population of each of the provinces and the amount of budget that is allocated to this, so that we can get some sort of comparison of how we are doing cost-wise vis-à-vis other provinces.

Miss Stephenson: Utilization rate is the thing.

Mr. Chairman: We will never be able to determine who does the better job--I suppose that is the unknown quantity--but at least we will get some financial figures.

Mr. R. F. Johnston: There is only one other thing I wanted to raise, and I hate to do this, since certain members are starting to puff.

Mr. Chairman: I am butting out.

Mr. R. F. Johnston: Can we have agreement, starting tomorrow, not to smoke during the sessions? Would that be possible?

Mr. Chairman: We are going to issue pacifiers to all the smokers on the committee so that they will not suck their thumbs.

Interjection: We have until tomorrow to fill our lungs?

Mr. R. F. Johnston: Go to it like crazy, but not in the committee. I would appreciate it.

Mr. Chairman: I lied to my executive assistant. I told her I had given up smoking, so maybe it will help me follow through on that.

Mr. R. F. Johnston: I would appreciate it.

Mr. Andrewes: I abided by that rule until I saw your colleague.

Mr. Chairman: That is when I started. I was not going to smoke at all until Mr. Cooke puffed up.

Mr. R. F. Johnston: He has indicated to me that he is willing to go along with us as of tomorrow.

Miss Stephenson: That means he will disappear regularly from the committee.

Mr. Chairman: Are there any further questions?

Mr. Baetz: My question has to do with the advent of the black-box technology. You are anticipating its greater use. My question is a very general one. How soon are we likely to expect this technology? By that I mean within the next five, seven or perhaps 10 years?

Particularly, what impact do you see? You will probably have to use some imagination and do some futuristic thinking. If you make a mistake, no one will hold you responsible. What kind of impact do you think this is going to have on the fine-tuning modus operandi that has been developed between the commercial sector and the doctors? In other words, this is the very question that this committee will be looking at. What impact is it going to have on these relationships and this balance during the next five to seven years? I realize it is a very general question.

Dr. Psotka: I will give you my philosophical musings on this area. I have been somewhat intrigued by it. Right now, we have a laboratory system that does 127 million tests. Very few of these are being done in doctors' offices, mainly because of quality. Physicians are more attuned to getting quality results. As Mr. Wiseman pointed out, they have not been able to. They did not have technicians available in their offices, the nurses were not into it and it was difficult to do.

If you go to our major labs, however, you will find that black boxes have been with us for quite a long time. Nowadays, when you walk into a lab you will not find pipettes and Dr. Frankenstein bubbling in the corner. You will usually find a beige box. It is a microprocessor and it is running up to 3,000 tests an hour using mini-samples. The latest one I saw did 3,000 tests an hour at 50 cents a shot. As far as it goes, that is not fair; one has to look at all other costs.

We now have the next step. We had the first generation of black boxes, which we all saw, perhaps even six or seven years ago. You could finally buy a box and do a blood sugar on yourself. It did one test and it was not all that accurate. I remember the box stated if it was up, it was up and if it was down, it was down, but do not put a number on it.

We have now gone to the next generation. It actually gives you a number. We have studies done at St. Michael's Hospital, for example, which compared them. They were within a very close range with the lab. In fact, the big conflict in hospitals now is whether these things should be done at the ward or sent back downstairs. Everybody is in conflict because, traditionally, this has not been the way to do it. There is always this traditional conflict.

What is happening now is the next generation of black boxes has come out. They do 20 tests. If you recall, I mentioned there are about 40 common

tests that everybody does: sugar, cholesterol, thyroid, calcium or electrolytes and so on. These are all going to be done in the doctor's office. The point of the matter is quality. The professionals and LTPT--the Ontario Medical Association's laboratory proficiency testing program--are concerned about the quality. Of course, there are vested interest considerations, profit and all that.

The real hook on the whole thing, though--and I think Mr. Sargent stumbled upon it--is that, more than likely, these things will be franchised. I suggest that the major lab firms will end up supplying them to physicians. They will guarantee the quality and undertake the proficiency testing. I think the debate about cost will then take place.

That is where I think we are drifting. If we do not have rules, regulations and control, these things will be all over the place. To be honest about it, Mr. Wiseman's fears about whether he is getting an accurate result may be something to be considered.

If you go to the recent literature, there has been a series of articles in JAMA, The Journal of the American Medical Association, on exactly this. Almost every state in the union has a dilemma on its hands. Some of them have regulatory legislation. The majority of them are insisting upon quality control. It is a whole new era.

16:10

We are sitting here. We do not have the problem yet, but it is starting to come. It is not a big problem, but I think there is interest in the Ontario Medical Association, the college and the ministry. We have had in the Ontario Society of Medical Technologists and the Ontario lab owners. Everyone is expressing concern about this, and there will be a lot of debate. I do not think we will have a problem, but I believe there has to be a debate.

Mr. Baetz: You are talking about a time frame of two or three years and then it is really going to be upon us.

Dr. Psutka: In two to three years we are going to be having more than a debate.

Mr. Chairman: You say 127 million tests are performed in commercial and hospital laboratories at a cost of \$525 million. On page 4, you say \$240 million was for laboratory tests performed in commercial labs. That does not seem to jibe with the less than 40 per cent that you list in the schedule.

Dr. Psutka: We were going through these numbers again this morning, and there is a slight variance. We have so many sources of data that for me to try to be accurate--you may be out one or two per cent hither and yon, but I think the macroslice is there. For example, it is very difficult for me to give you hospital data because hospitals do not get paid by LMS units. They get a global budget. They do report testing to the ministry. We have had to try to factor in their costs versus those of the private labs and try to give you apple-and-apple comparisons, but it is very difficult to do.

Mr. Chairman: Is that the reason one of the schedules says 39 point something per cent, and yet the \$240 million is more than 50 per cent?

Mr. LeNeveu: I think the \$240 million may be another fiscal year, 1985-86, where we did not have the hospital data.

Dr. Psutka: One of those schedules is 1983-84.

Mr. Chairman: Oh, yes. I am sorry. Okay.

Mr. LeNeveu: We had \$207 million for 1984-85.

In another table we tried to make it purified as well, not to mislead the committee, because the public health laboratories do some tests. We try to take out those tests that are comparable to what goes on in hospitals and private laboratories and exclude water tests and so forth, so that you are looking at a constant series. We titrated some of the figures to try to get them in a standardized format, which is tricky to do. In one place you are counting dollars and in another place you are counting services. It does not work that easily, but it is very close to being accurate.

Mr. Chairman: Okay. We are getting very medical lingo: "titrated." I remember that from when I was in chemistry for about three days.

Miss Stephenson: As a matter of fact, if Dr. LeNeveu had been more accurate, he would have said "manipulated" the figures rather than "titrated" the figures.

Mr. Chairman: I would have preferred "distillation." That is something I can equate with.

Miss Stephenson: I am not sure I would call it a "distillation." "Filtration" would have been more appropriate.

Mr. Chairman: Perhaps we can move on to the next item, which is the emergency health services.

Dr. Psutka: That is also included in your package. I will just pass around two other handouts, which I will mention, that go with the package. One of the handouts is a discussion paper we circulated across Ontario, while the other is a series of guidelines for trauma units.

I will try to skim along here because of the time constraints.

Mr. Chairman: Excuse me, Doctor. Is it also included in that binder you were talking about?

Dr. Psutka: No. The beige one might be, but the white one will not be.

Mr. Chairman: Fine. Thank you.

Mr. LeNeveu: This paper will definitely be in your book tomorrow. I will bring the binder with me.

Dr. Psutka: The emergency health services program at the ministry is there to provide rapid response, emergency treatment, transportation and access to definitive care to all emergency patients across Ontario.

If you look at the program, you will find there are two units to organization. There is a planning and developing unit and an operational unit. The planning unit is responsible for the development of policies and programs, the training of ambulance attendants and the quality assurance of services provided by the ambulance system. The operational unit manages the provincial

air and land transportation system. It also operates directly nine land services, five air ambulance services and the planning and implementation of heliports. It also--and this is something that was missed here--manages central ambulance dispatch centres.

The emergency health services program runs on a budget of \$131,874,700 and it employs a full-time staff of 484, which includes the head office staff of 60 and a field operational staff of 424. It is important to note that the 424 are the people who man the nine ambulance services, the air ambulance services and the dispatch centres that we operationally run. They are not front-office people as far as that goes.

The Health Insurance Act and regulations govern the use of the ambulance services as an insured benefit. The Ambulance Act and regulations set out the Minister of Health's obligation to provide these services, the terms and conditions for licensing ambulance operations, standards for vehicles and equipment and standards and qualifications for full- and part-time employment as ambulance driver-attendants.

It is important to know there is no essential service legislation for ambulance operations. Those who are employed directly by the ministry are prevented from striking under the Public Service Act. Of the total number of people employed in the ambulance system, 10 per cent are covered by that act. In addition, 21 per cent of ambulance driver-attendants are hospital employees and are prevented from striking under the Hospital Labour Disputes Arbitration Act.

You are probably aware that there are five types of land operations. You will notice there are 65 services that are hospital-based, 71 privately operated, 32 volunteer, five municipal and nine ministry. The ministry funds 100 per cent of all ambulance services and provides all of the vehicles and telecommunications equipment, except in Metropolitan Toronto where the ministry funds 75 per cent of approved budgetary costs.

All ambulance services are operated on a cost basis. There is no opportunity for any operator, including the private operators, to make profits from operating an ambulance service. Private operators receive payments through a management compensation plan for managing the operation and the ministry's assets. This plan is based on the number of hours of management time required to manage the service, and this number may vary depending on the size of the operation.

Management compensation may also include the time of an assistant manager, a secretary and/or a bookkeeper. It is up to the private operator to decide how administration is to be handled and how the management compensation funds are to be spent. Management compensation is kept separate from service operational funds, which are subject to line-by-line budgeting and audit procedures. I think it is also important to note that ambulance owners who have a licence can also generate extra income by working directly on the ambulances themselves. In other words, if an owner-operator decides to do 40 hours in the vehicle, he will get paid for that besides receiving the management compensation.

The breakdown on cost is outlined: hospitals, \$22 million; private operators, \$39.5 million; volunteer, \$1 million; municipal, \$25 million; and ministry, \$11.8 million. That is the breakdown of the cost of running those services.

The ministry also operates five dedicated air ambulance services and uses chartered and scheduled aircraft to provide cost-effective backup to the dedicated services. There are now dedicated air ambulance services in four northern air ambulance bases at Sioux Lookout, Timmins, Thunder Bay and Sudbury and one southern air ambulance base in Buttonville outside of Toronto.

The southern service was established in 1977 and is currently staffed by 11 specially trained, critical care attendants or ambulance officers to provide full service. The northern portion of the air ambulance program was established in 1981. Each of the four northern air ambulance bases is now staffed by 11 air ambulance escorts and provides a full 24-hour service. It is planned that all of these dedicated aircraft will have critical care attendants on board by the end of this year. The dedicated air services carried out 3,656 transfers in 1985. Besides that, there are 25 chartered aircraft companies scattered across the province which are on the ministry's roster. These companies have met the ministry's prequalification standards, including improved criteria for medical and survival equipment, aircraft operation and regular inspections.

You will note that our call volume, which is listed below in this paper, illustrates that in 1982 our total call volume was 641,897 trips, whereas in 1985 we were up to 776,024 trips. The air program has gone from 8,126 in 1982 to 12,408 last year.

16:20

As for the people working in the ambulances, all full-time ambulance attendants are required to pass the one-year ambulance and emergency care program offered through various community colleges across the province and to achieve their emergency medical care attendant certification. On the other hand, some full-time people who were hired prior to 1975 are exempted through a grandfather clause, but they too must have a standing in the fundamentals of casualty care, another training certificate.

The standard of training acceptable for part-time people is that they must have at least first aid and cardiopulmonary resuscitation. You cannot work more than 24 hours a week with those minimal standards.

There is a breakdown in the paper, which I will not read in the interest of time. It points out the full-time versus part-time that we have at this time. Among our full-time people, 60 per cent have EMCAs, 12 per cent have fundamentals of casualty care--we have nurses who do this--and less than one per cent of the full-time people have only first aid or CPR.

Fleet inventory: All land ambulance vehicles in this province are standardized, so no matter where you go in Ontario you get the same standard of vehicle and the same standard of care. At present, the fleet totals 605 vehicles. As you can see, it is broken down into various categories. At any one moment, about 100 vehicles are being repaired or are in for conversions or disposal. There are emergency support units. These are units that are scattered across the province in case of disasters. There are five critical care transportation units. These are vehicles that we have put in major teaching centres to back up the air program to move the critically ill and injured between hospitals. We have emergency response units and administration vehicles.

If you look at the provincial fleet--these numbers exclude Metropolitan Toronto vehicles--you will note that we have increased ambulances from 537 to

588. In total, the active ones are only 487. We have 29 emergency support units and the administrative vehicles have dropped from 53 to 35.

As far as the history is concerned, it is important to note that prior to 1966 there was no emergency health system or even a system of ambulance delivery in the province other than an ad hoc community-by-community nonsystem. Prior to 1966, there were papers produced by the Ontario Medical Association and the ambulance operators' association among others requesting that the government do something about this nonsystem. In 1966, the Ambulance Act was passed to provide the Ontario government with the authority and responsibility for licensing, standard-setting and the combination of better communications and improved ambulance services.

In 1967, the very first training program was set up at Camp Borden to train ambulance personnel beyond the first aid level.

In 1968, the emergency health services division was set up as a division of the Ontario Hospital Services Commission and it was given a budget to develop a provincial ambulance system with centrally controlled budgets.

In 1970, there were further changes to the system. There was an improvement of the training package to include a certificate in the fundamentals of casualty care. There was also the introduction of the Ontario ambulance services information system which was a way of gathering data on what was happening in the province.

In 1972, the Ontario Hospital Services Commission merged with the Ministry of Health and the emergency health services division then became the ambulance services branch of the Ministry of Health.

In 1975, after much debate, further major amendments were made to the Ambulance Act that covered licensing, qualifications for employment, vehicle and equipment standards, etc. EMCA programs were introduced to community colleges and it was made mandatory to have an EMCA to work full-time on ambulances.

Around the same time, in 1976, interest was developed across Canada and North America by the Ontario Heart Foundation with its CPR training courses, and in 1977 we began to see the initiation of the advanced cardiac life support program in three communities, Sault Ste. Marie, Oshawa and North Bay.

Surrounding all this was a lot of debate and dialogue among the various user groups in the province. National standards were set under the Canadian Medical Association for ambulance attendant training in Canada. Finally, in 1980, the Ministry of Health and the Ontario Medical Association published a joint physician paper pointing out that a modern emergency health services system should be developed in the province and cabinet gave approval for this to take place in 1981.

In that year, the ministry made EHS a very high priority and began to expand its mandate beyond the provision of basic land ambulance transportation. The new division of EHS was created to act as a single focus for all planning, direction and co-ordination of emergency services in Ontario. EHS is now defined as a system of 15 interrelated services and activities that are required to provide victims of accidents and sudden illnesses and injuries with the best possible chance of survival and recovery. The new division began to function officially at the beginning of 1982 and the goal was to develop this modern emergency health services system.

The beige-covered book we have handed out to you is the blueprint for this development. This blueprint has been made available across the province and is in the hands of emergency health system planners in every community.

The planning network is province-wide. It was set up over the past few years to assist the ministry in the building of this system. The network is based primarily in the already established district health councils and is made up of approximately 32 local EHS committees, six regional committees and a provincial EHS advisory committee. These committees are formed in all these areas and they are charged with the responsibility to analyse their local community resources and work with the government to develop an emergency system based on provincial guidelines and policy directions that come from the provincial mother committee.

During the past four years, the planning network has been instrumental not only in promoting this concept of a total system but also in getting a common vocabulary in use across the province and a common set of directions for EHS development. To do this, we have had to build resource inventories and utilization data bases. We have increased public awareness not only through a media relationship but also through first aid and CPR training as well as having closer links between hospitals, ambulance services and medical, nursing and ambulance workers in the provision of ambulance services.

In the past few years, the ministry has taken a number of steps to improve the quality of care and service provided by the land ambulance system. We have improved and revised the financial and administrative guidelines so that while four or five years ago we were having audit difficulties with the administration of budgets, that has been pretty well clarified.

The consolidation of a number of smaller services has taken place. For example, Fenelon Falls has now been amalgamated with Beaverton, and Sutton has amalgamated with Queensville. We have relocated ambulance bases to improve response time in many communities such as Windsor, Kingston, Ottawa and Simcoe.

Major improvements to ambulance design have taken place in the past few years, including the addition of air-conditioning, enhanced lighting and warning systems and interior surface protection. We were just discussing that this morning at another meeting.

The air ambulance program was introduced in northern Ontario in 1981. Aircraft were placed in Sudbury, Timmins, Thunder Bay and Sioux Lookout. There have been massive improvements to this service over the past few years with the construction of hangar facilities in Sudbury, Thunder Bay and Timmins. We now have 65 licensed helicopter pads. These are day-and-night licensed helicopter pads linking hospitals across the province.

We have a single central air ambulance communications centre with a computer-based management information system that includes the ability to co-ordinate and book all the neonatal transfers for the province. We now have in place a neonatal bed inventory for the total province that allows any physician in Ontario to access a neonatal high-risk bed through one source.

There is a system of prequalification that is an industry trendsetter. This province has set up criteria for prequalification for chartered aircraft, and 25 people have qualified. This has taken the chance out of taking a chartered aircraft as far as health uses are concerned.

16:30

Mr. Sargent: (Inaudible) on standby.

Dr. Psutka: You cannot get on standby unless you prequalify. Not everybody can get on this list. That may be because they do not have the equipment, the manpower, the support staff or the maintenance, or for a lot of reasons.

There have also been several initiatives aimed at improving the productivity and cost-effectiveness of the program, such as central fuel purchasing and improved scheduling of aircraft. It is also worth noting that in the past few years we have been able to bring the cost of using the dedicated aircraft down from more than \$4,000 to \$2,735. This year it will be lower than that.

Miss Stephenson: Remind me of what it was in 1977.

Dr. Psutka: About \$10,000.

Miss Stephenson: About \$10,000 per call.

Dr. Psutka: I am guessing. but it was pretty close to that. Utilization was very low.

Miss Stephenson: It was closer to \$12,000, as a matter of fact.

Mr. D. S. Cooke: But that would have been for one or two calls.

Dr. Psutka: Bandage One has been averaging 150 to 160 trips a month in the past year in the southern part of the province. All the utilizations are up.

Miss Stephenson: I live right under the flight path of Bandage One. Believe me, it flies six, seven or eight times a day.

Dr. Psutka: We are still trying to determine where other members live, using sophisticated radar-scanning systems. Actually, the beige books have a radio transponder in the cover.

Miss Stephenson: That is right. We use a little radar thing.

Mr. Andrewes: We are still waiting for the--

Dr. Psutka: Ask and you shall receive.

Turning to the central ambulance communications system, approval was given in 1980 to implement a province-wide system of central communication centres. There are now 17 in operation, and they provide a central focus for communication and monitoring. In other words, they provide a management information system and a control of ambulance resources.

This has resulted in an improvement in our response times and a much more accurate response. There is better co-ordination of patient transfers, and we now have a current management information system that is being used by the committees I alluded to earlier to help us to develop the emergency health system in various areas of the province.

What we are seeing in these centres also is the introduction of computer-assisted dispatching. We now have in place a priority card index, which is an algorithm used by the dispatchers to dispatch an ambulance according to a predetermined set of criteria. We intend to have that on a computer very shortly, so that when you end up talking to the dispatcher, the dispatcher will be following a very controlled response.

There is also consolidation of a uniform policy and procedures manual, and we are looking forward to computer-based mapping and street indexing systems.

By the way, we used to call these things CADs or central ambulance dispatch centres, but that was confusing people because of CAD/CAM, which is computer-aided design/computer-aided manufacturing. We have changed them to CACs or central ambulance communication centres. I thought I would explain that in case you are having difficulty.

Interhospital patient transfers are a concern to the ministry. They make up 32 per cent of all our ambulance calls. Patients who require interhospital transfers can be divided into two groups: either routine or emergency patients requiring critical care transfers. They are often sophisticated problems.

A safe and efficient interhospital transportation system serves as an important link for the various levels and types of hospital care that exist in Ontario. This transportation is also essential in the rationalization of highly specialized and costly hospital facilities. For example, if you have a burn centre, the issue is how to get the burn patient to the burn centre.

Mr. Chairman: We have one in Brampton. They can use ours.

Dr. Psutka: A burn centre?

Mr. Chairman: Peel Memorial Hospital has a burn centre that has never been operated.

Dr. Psutka: I will get into that in a minute. What time is it?

The EHS program has recently taken a number of steps to improve interhospital transfer services, such as: better scheduling and dispatching made possible by developments in central ambulance dispatching and standardization of dispatch procedures; and increases in the number of ambulances and crews in high-demand areas, such as Ottawa and Windsor.

The introduction of critical care transport units has been accomplished. The units are dedicated specifically to providing interhospital transportation for critically ill and injured patients. By the way, these vehicles are located in London, Hamilton, Kingston and Ottawa; they are there as a regional resource. Teams of doctors, nurses and technicians are called upon to man them and go out to the smaller hospitals and bring the patients back in a safe environment.

The development of provincial guidelines and the promotion of better communications between sending and receiving hospitals have been accomplished. This has happened actually through transfer guidelines which we have promulgated with the assistance of the Ontario Medical Association and the Ontario Hospital Association. This has definitely helped hospitals in addressing the issue of patient care responsibility.

We have also done some local transfer studies. We hope within the next year this will lead to the introduction in a few centres across the province of multipatient transfer vehicles which will probably go on predesignated routes. This will mean patients will be moved efficiently throughout the hospital system without depending upon an ad hoc approach, which is in place at this time.

As you are all aware, the paramedic pilot project, which began in 1983, was completed successfully in October 1985. A number of paramedics were trained and studies have been carried out. If I recall properly, we presented a report to the estimates committee last year. There were more than 6,000 patients treated between June 1, 1984, and May 31, 1985. More than 5,700 delegated medical procedures were carried out. Most of these, shall we say, life-saving procedures were carried out on patients with heart-related illnesses.

Approval has now been obtained for the ongoing status of the Toronto and Hamilton programs as well as for the expansion of paramedic services across the province, with five communities expected to come on line with programs in the next year and others to follow.

Mr. D. S. Cooke: They have not been chosen yet, have they?

Dr. Psutka: Where we stand on that is that we are actually waiting for the communities to present their papers. At this time, I still have not received a paper, but that does not mean they are not coming. I know who has the papers in the works, but it is taking them time. That is why we feel we are right on target, because we are insisting upon community commitment, local planning and the ability to handle the program locally. That has people thinking seriously about how they are going to do it.

In May 1986, the college of physicians and surgeons accepted all the recommendations made by the ministry and endorsed the continuation and expansion of the program. So all the i's have been dotted and t's crossed, and we are ready to roll; it is just a matter of getting it done.

Mr. Chairman: Whose employees would they be?

Dr. Psutka: It depends on who they work for in the community. In Toronto they are employees of the metropolitan municipality. If they are in Ottawa, they would be my employees. In London, they might be private or whatever. In Hamilton, they are private.

Mr. Chairman: I do not want to go too far afield, but is there any legislation in place to protect the gamut for which they may be legally responsible for the services they perform?

Dr. Psutka: You have to remember how they perform their services. Their performances are under the--what is the word I am looking for here?

Miss Stephenson: They are delegated.

Dr. Psutka: They can only do what they do, which are called delegated acts, if those acts are delegated to them under the authority of a responsible physician who works in a base hospital, which is the next paragraph.

Interjection.

Dr. Psutka: Technically speaking, that physician is responsible for who they are, their training and their capabilities. That is why the college of physicians and surgeons has been involved in the ongoing evaluation of the program.

Base hospitals are something the ministry has been dealing with. It is a new term. Two guidelines have been established and sent out across the province. They were developed with the help of the Provincial Emergency Health Services Advisory Committee and input from the district health councils and the many EHS planners from right across the province. We not only put out the first paper but also received commentary from all the people and then circulated a second paper with changes based upon their comments.

A base hospital is defined by the ministry as a designated facility that will provide leadership and medical direction in the provision of prehospital and interhospital emergency health services in a specified geographic area. It is also the hospital that is responsible for the training and medical control of paramedic programs.

The first base hospital was officially designated just a few days ago in Parry Sound. Three other hospitals, McMaster University Medical Centre, Toronto General Hospital and Sunnybrook, have assumed the role of base hospitals on an interim basis for the pilot paramedic program, and they are at this time filling out a few pieces of paper which will get them official designation. We have said to them: "We do not care who you are. You have to jump through the hoops too." To become full-time, ongoing base hospitals, they have to do a little bit of paperwork for us.

16:40

The introduction of base hospitals enables close medical input into the quality of care rendered by ambulance services and makes the ambulance systems truly an integral part of the total health care system. One of the problems we had before was that the ambulances were out there, the doctors were over there and the nurses were over there, and they were not really getting along, but this has got them to work together.

For critical care facilities, the ministry has recently released guidelines on the categorization of trauma facilities. That is the white-covered document we have circulated. These guidelines were developed by a subcommittee of the Provincial Emergency Health Services Advisory Committee and represent an important step in the development of the provincial trauma care system. The guidelines set out system and facility criteria which will assist health care planners and providers in assessing present trauma capabilities and in planning future service adjustments and improvements.

Trauma centres will be designated based upon these criteria and will be made on a regional basis by the ministry on the recommendations of health councils in consultation with the area EHS committees, hospitals and the provincial advisory committee. It is expected the same approach will be used in the future for categorization of other special care or critical care facilities, such as for burns, poison, spinal cord injuries, psychiatric and high-risk infant emergencies.

To be blunt, we hope these guidelines will have a system result, and it will eliminate the confusion we have right now. It is true that there are burn units, but they are there, and they are really not a total package. For a physician working in an emergency room in the middle of the evening, when that

serious burn comes in, we do not have time to think where the nearest burn unit is; it should be automatic. These referral patterns should be in place, and in that case, we will have better care.

The other thing we are doing at the EHS division is improving service delivery through advanced technology. We talked earlier about the technology in the central ambulance communications system. We are also in that area. Telehealth falls under EHS, and we are working on advanced audio, video and other telecommunications transmission modalities to improve access to resources and continuing education, especially for people in the north.

The central registry is a computerized system which, when put in place in the cities of Toronto, London, Windsor, Ottawa, Sudbury and Thunder Bay, will give the health care providers, the dispatchers and the hospital admitting departments an ongoing, up-to-the-minute listing of what beds are available and where they are. To my knowledge, Toronto, Windsor and Sudbury are very close to having this. The money has started to flow, and I expect these will be up and operational in those communities by the end of the year.

We are also working with the Ministry of Natural Resources on a digitized mapping technology for the province. When this mapping has been standardized for the province, dispatchers, whether they be police, fire, ambulance or even taxi or Pizza Pizza, will have in front of them, on a computer display, exactly where you live right down to the size of your garage, and this will be a standard mapping system for the province.

The other thing we are somewhat intrigued about--and this is what I was alluding to earlier when somebody asked me about management information systems--is that the emergency health services division has completed a feasibility study and is now proceeding with the development and testing of a prototype management information system for the emergency departments of the province. This system is now being designed to create a uniform database for Ontario emergency departments. It is our purpose to take this database and combine it with what we hope will be user-friendly audit software, which will then allow health care providers in each of these hospitals to monitor, review and improve the standard and quality of care available in their respective departments. We hope to do this on a uniform basis rather than have 202 hospitals counting differently and doing different things.

Other things we feel somewhat proud of in the past few years are perhaps not as tangible, but we have definitely increased public awareness across the province in first aid and cardiopulmonary resuscitation. I suggest that EHS has been a prime instigator in many communities in developing the 911 emergency telephone communications system. The linking of hospitals, doctors, ambulances, nurses and all this into a much more efficient system has been a result of all this activity. Truly, Ontario at this point probably has one of the finest systems in Canada, at least, if not in North America.

What do we want to do in the next few years? We are still looking at improving the central ambulance communication centres. As I mentioned earlier, we are looking at multiple-patient vehicles; definitely paramedic service in qualifying communities across Ontario; guidelines again, not only for trauma facilities but also for other critical care facilities; and finally the most important thing, which is the introduction of measures and approaches to monitor and ensure the quality of care through the development of that management information system for emergency departments.

That is again an overview of emergency systems. If there are questions--I know there are going to be questions.

Mr. Chairman: We have four people on the list now and we have 15 minutes left. Four into 15 is about four minutes each. If anybody else wants to ask a question, we will divide it again. Anybody else?

Mr. Wiseman: Under central dispatch, other than maybe in a remote part of the north, is all the province covered now with the central dispatch?

Dr. Psutka: No. We have 17 centres up and running and we are covering 60 to 70 per cent of the total land mass. We still have a fair amount of work to do in the north and in some of the southern areas; for example, around the Peterborough area and in places like that.

If you look at the Golden Horseshoe, we pretty well have covered everything, I suggest, from Niagara Falls, London, Kitchener and Barrie all the way over to Lindsay. This is probably the reason that, when the tornado hit Barrie last year, it went off very well. Everything was completely controlled through the dispatch centres.

Mr. Wiseman: Why would the people in the central part be reluctant to get into a system such as that, which in my opinion seems to reduce the response time tremendously?

Dr. Psutka: In a nutshell, it comes down to turf; but I think those days are gone. There was a fair amount of resistance three or four years ago, and it boiled down to certain people not wanting to have the ministry know exactly what was going on. To be blunt about it, we now know what is going on, and when we contract for services, as it were, we know whether we are getting--

Mr. Wiseman: I do not want to take too much time on that. I would encourage places to have it. We have it in our area, and it does improve the response time.

Dr. Psutka: There is a lot work still to be done there.

Mr. Wiseman: The other part, which we discussed at one time in the committee, is about the new program--I know you might not want to talk about it because maybe it is a government decision--where people coming from the north have to pay their ticket in advance and then recoup that money later on. Is that working satisfactorily, or are you recommending that perhaps this be looked at? Is it in place yet?

Miss Stephenson: But it is not--

Dr. Psutka: It is a health program.

Miss Stephenson: Yes, it is a health program, but it is not one of the emergency health programs.

Mr. Wiseman: Is any consideration given to a mother accompanying a child or something like that and being paid for--

Mr. LeNeveu: Under the northern transportation grant program, a person under 18 years of age will be permitted to be accompanied. The program has been going better than we thought, actually.

Mr. Wiseman: What does a parent have to pick up then, or whoever comes out?

Mr. LeNeveu: The province will pay 100 per cent. There is a standard plan formula, and the parent and the child will qualify for the grant.

Mr. Wiseman: Up front?

Mr. LeNeveu: No. The program has been operating basically on the premise that you go to your general practitioner or specialist in the north; he recommends that there be a referral either in the north or to the south.

Actually, we are relatively surprised that there is a larger number of referrals in the north than we had thought there would be over the 300-kilometre limitation. When you have seen the specialist, say, in the south, the form is sent to the Ontario health insurance plan and a reimbursement cheque is issued.

Arrangements have also been worked out with a number of northern municipalities and with the cancer society and Easter Seals, because there are a limited number of people who are making arrangements for the tickets; that perhaps causes a problem for them.

We tried to base our model basically on the Ministry of Community and Social Services model. Over the years, the Ministry of Community and Social Services has had a lot of experience in dealing with special circumstances and unusual cases. We liaise with them and we put that into place. During January and February--the program started in December--we had a number of complaints, but have not seen any letters lately of problems in that area, so they are diminishing. We tried to design the model that works basically the way in which the local municipality works.

Mr. Wiseman: If there was a municipality in the north that did not have a cancer society set up to assist someone, if the doctor phoned you in the Ministry of Health, do you have the authority to pay for that up front? A lot of people may not have \$200 or \$300--we discussed this before--or have a credit card as do most of us that we can pay later on.

Mr. LeNeveu: As I said, we have been trying to work out the other programs that we tie in to municipalities and it seems to reduce virtually all of the problems, but there still may be an individual, isolated situation that you are alluding to. There have been a lot of problems that have to be thought through as the programs come in to place.

Mr. Wiseman: I know there are others who want to ask questions, but is everyone funded at 100 per cent of the ticket? You mentioned 18-year-olds and under.

Mr. LeNeveu: No.

Mr. Wiseman: Do adults get 100 per cent funding?

Mr. LeNeveu: No, it is not 100 per cent of their ticket. There is a standard formula that was developed. Basically, the formula was about 75 per cent of the air fare. Everybody qualifies for that same grant level. It is a distance-related formula and it starts at \$125 and goes up to about \$350, which would be the air fare from, say, Kenora to Toronto.

Mr. Chairman: Mr. Wiseman, because I am sure it is very important information to you, perhaps you could speak, if you would not mind, to the gentleman afterwards.

Mr. LeNeveu: Yes, sure.

Mr. Chairman: Do you have any further questions with reference to the presentation?

Mr. Sargent: I am very impressed with this presentation, especially by Dr. Psutka and Ron LeNeveu. I think we are lucky to have civil servants like this. It makes you feel good. I am very much impressed with this overview. They say if you ever have a heart attack in the United States, Seattle is the place to have it. They have proved it by the great service they have with the fire departments and the tie-in they have down there. With the tie-ins we have, I have a lot of respect for what St. John Ambulance is doing, and things like that.

The funding you were talking about is totally provincial. I noticed last night that Mr. Muldoon has given Quebec \$21 million of federal money for seven air service ambulances to seven outlying areas.

Mr. Chairman: You do not want our ministry to comment on that, do you?

Mr. Sargent: No, but are you supplemented by any federal money? Are you getting any federal moneys towards this?

Dr. Psutka: Other than the normal Ministry of Health transfers from the federal government, I am not aware of anything specifically given to us for emergency health services.

Miss Stephenson: I thought it was for airport construction, was it not, Mr. Sargent?

Mr. Sargent: The motivation was ambulance.

Miss Stephenson: For ambulances, yes, but it was airport construction.

Mr. Sargent: I think that was airport construction, yes.

Miss Stephenson: The Ministry of Northern Development and Mines has been doing that here for years and years, and the Ministry of Transportation and Communications has been providing for airport construction so that ambulances could get in there.

Mr. Chairman: I do not think we are here to look into the commercialization--

Mr. Sargent: No.-

Regarding the good Samaritan laws, is there not a good Samaritan law in effect that anybody aiding in this business is free from any legal malpractice or whatever?

Dr. Psutka: There is no good Samaritan law in Ontario. It is the opinion of most lawyers, the College of Physicians and Surgeons of Ontario, and everybody with whom we have consulted that you do not need one. Basically, if you are not a doctor or a health care provider, but just a civilian, and approach a patient who is in distress, if you do whatever you can do to the best of your ability, then you are not going to be culpable for anything.

Mr. Sargent: I believe you guys have done a good job in presenting us with a good system.

Mr. Chairman: You are looking at Dr. Stephenson.

Mr. Sargent: Yes, looking at Bette there, she had a lot to do with it.

Miss Stephenson: Not by a long shot.

Mr. Chairman: Very good. You and Dr. Stephenson can go out to dinner on that.

Mr. Sargent: If we had any money.

Mr. D. S. Cooke: I have a couple of questions. What are the criteria used to determine whether an ambulance service is in the private sector or the public sector or whether it is municipal?

Dr. Psutka: There are no criteria. What we have is what I suggest was left over from before 1966. If you go back to those days, in my town, Grimsby, the ambulance was run by the funeral--sorry, the nursing home.

Mr. Chairman: That would be a ride worth having, I would think.

Dr. Psutka: I can always talk about my town, but in other communities--

Mr. Andrewes: Vested interest.

Dr. Psutka: --some funeral parlour people did run ambulances. Talk about vested interest. What has happened is that in the years following 1966 there was a definite collapsing of licences. I would have to go back and check documentation, but back in those days there probably was a policy to have them go to hospitals. That is why we have around 60 hospital services. Then some communities got out of the business and nobody wanted the licence. I guess it was then the emergency health services division of the Ontario Hospital Services Commission--

Mr. LeNeveu: That was the Department of Health.

Dr. Psutka: Yes, the Department of Health ran them. What we have is a group of private hospitals, etc. and, seriously, right now we do not have a policy. The licences are there. I must confess that we would like to see rationalization. If there is need to amalgamate, if this is better and these things are debated, then we will go in that direction.

Mr. D. S. Cooke: Are there any plans or reviews going on in communities where there are the public and or private sectors? In some cases, the city could have the Ontario government running the service and in the county you could have three or four different private ambulance services.

Dr. Psutka: The classic example would be in the Hamilton-Wentworth region where there are two private services and a municipal service. In fact, there is a third private service on the fringe. There is a group of ambulance services in that area.

One would have to ask, "Is this good or bad?" At present, it functions quite well. We have a very good system there. Basically, what makes it all

work is the central ambulance communication centres. With tight budgeting and with the centres, I really do not care how they run.

Mr. D. S. Cooke: It is fair to say that this is not a typical example of the private sector.

Dr. Psutka: No. It is very atypical. There is no incentive to get more patients.

Mr. D. S. Cooke: Really, the only private sector involvement is the management.

Dr. Psutka: Exactly. Also in many cases, the private sector owns a building that we rent at fair property value, which is estimated by using various agencies to give us a price.

Mr. D. S. Cooke: The final question I have is, why is it that where there are private sector ambulance services and the budgets are determined by the ministry there is not an amount budgeted so that the ambulance workers in the private sector are paid at the same rate as the ambulance employees in the public sector?

Dr. Psutka: This is a very tricky issue. I am trying to remember the exact year, but there was an attempt at--if you want to use the word "catch-up"--four or five years ago, and the services in the province came very close together.

What we have here, by the way, are the vestiges of the original system. If you look at the system in the province, not all ambulance employees are unionized. The present unions are many. There is Ontario Public Service Employees Union, the Canadian Union of Public Employees and the Service Employees' International Union. Some hospitals are unionized and some are not, so we have a variance; there is not one standard. We have a Metropolitan Toronto group under CUPE, but basically its negotiations fall under another group within the metropolitan regional structure, which gives them various advantages.

In our own group, we negotiate the OPSEU contract. The ambulance attendants, of which there are 400, happen to be lumped in with a lot of other people and it causes a lot of variances. If you look at the wages across the province, it is hard to establish a norm, because you will find the people in Toronto are higher paid than our people. Our people are higher than somebody else, but some of the privates out there have negotiated even higher contracts than our people. We then have nonunion services, and it is extremely difficult. I think we are aware of this. It is difficult to know what this pocket you suggest should be; in other words, where do we draw the line? That is the issue.

As it stands, what we say is that the people who manage the service and hold the licence negotiate. They negotiate in good faith, and it is hoped they come up with an agreement.

Mr. D. S. Cooke: It is difficult for private ambulance operators to negotiate, though. You guys might as well be at the bargaining table.

Dr. Psutka: Yes and no.

Mr. D. S. Cooke: I do not mean you should be at the bargaining table, but I am saying that when you set the budgets, you are intimately

involved with determining what the private ambulance operator can offer at the bargaining table, except when we had Bills 79 and 111, which basically set the increases. Metropolitan Toronto would then pay the highest rate.

Dr. Psutka: It has literally run about 10 per cent more than the best ministry rate over the past few years, again depending on the bargaining unit. In the metropolitan region, the bargaining unit includes other highly paid technical workers. Therefore, they tend to get an increase which is not based upon ability more than it is on the bargaining unit.

Mr. D. S. Cooke: When you are dealing with three or four ambulance services in a region and, therefore, there are three or four different bargaining units and perhaps three or four different wages, does leap-frogging occur?

Dr. Psutka: Yes.

Mr. D. S. Cooke: That would be one rationale for why it might make sense to have a common employer, at least in a region.

Dr. Psutka: There have been some approaches in that area in the last while, and that is still being debated.

Mr. Polsinelli: I will take less than five seconds to ask my question, as Mr. Cooke addressed the second one I was going to ask.

On page 5 you have a chart indicating the training levels of the ambulance driver-attendants. Is that to be distinguished from the ambulance attendants? Are they different people?

Dr. Psutka: No. What you see there is a breakout of the qualifications of the people who are in an ambulance. In other words, as I said, you do not get to work full-time in an ambulance in this province unless you have emergency medical care attendant training, which is a one-year community college program with certification. You can work full-time if you have been grandfathered.

Mr. Polsinelli: If you have what? I am sorry.

Dr. Psutka: You can work full-time if, before 1975, you were in the system and you have a pass standing in the fundamentals of casualty care. Many of the people who have been in the system for many years fall under that, and you will see those are the 12 per cent of the 2,300 who are FCC.

Mr. Polsinelli: Let me tell you where my concern comes from. In the previous line, you indicate that part-time and volunteer staff all have first aid and cardiopulmonary resuscitation qualifications.

Dr. Psutka: Yes.

Mr. Polsinelli: Then I look at this table for the ambulance driver-attendants, and I see that only 43 per cent of the part-time have--

Dr. Psutka: No. That is a breakdown of the total: 14 per cent have EMCA; 28 per cent have FCC; 19 per cent have community college training but have not written EMCA; and then 43 per cent, the remainder of the 1,200 part-time people, are in the ambulance with first aid and CPR.

Mr. Polsinelli: Thank you.

Dr. Psutka: I should have brought other tables. This has definitely improved. Our aim has been to improve the quality of the breed. Last year I recall going up to Denbigh. The volunteer service there was a very positive affirmative action program because the majority--I think it was 95 per cent females--had all got together, passed the FCC and were now on their way to getting the EMCA. We encouraged that and helped them. Of the \$1 million that you see being spent on volunteer services, a lot is going for educational things, encouragement of these programs and things such as that.

Miss-Stephenson: Can I ask how we did with persuading some of the grandfathered people to go back to do their EMCA? Were we successful at all?

Interjection: Yes, surprisingly.

Dr. Psutka: Seriously, they have gone back; many of them have written it. There have been some problems. The real problem that is facing them, by the way, is that unless they have EMCA, they cannot move around. They are grandfathered, but they have to stay where they are. Therefore, that is the incentive to go back to school.

Mr. Chairman: Thank you very much.

Mr. Polsinelli: Can I ask one more tiny question?

Mr. Chairman: Thank you very much.

Mr. Polsinelli: Can I ask one more tiny question?

Mr. Chairman: At the risk of requiring somebody to give you cardiopulmonary resuscitation, sure, go ahead.

Mr. Polsinelli: I would assume they would total 100 per cent. Why does the one on the right total 104 per cent and the one on the left--

Miss Stephenson: It is rounded.

Dr. Psutka: When they give me my management information system for my--

Mr. Polsinelli: --the one on the left is 99 per cent.

Dr. Psutka: I have to go through that. I need a black box for data.

Mr. Polsinelli: I take it the numbers are rounded off.

Dr. Psutka: I think you are right.

Mr. Chairman: Thank you very much, Dr. Psutka and Mr. LeNeveu. Are you we going to see you tomorrow? I notice they have Ministry of Health. I guess that is not you two gentlemen.

Mr. LeNeveu: Mr. Chairman, tomorrow the key presenters will be Randy Reid and David Corder. David will probably consume four fifths of the time because the topics identified by the committee fall under his responsibility. I thought I would come over tomorrow. The deputy asked me to come over just to bridge today versus yesterday, but they will probably stay here today if that

is okay. We will bring that book for you tomorrow, which has all the papers in it.

Mr. Chairman: I wonder if you can bring two extra copies because we have two people coming to see us on Thursday and Friday who may wish to have that book to determine what direction--

Clerk of the Committee: We have asked for extra ones.

Mr. LeNeveu: We will have 20 copies tomorrow.

Mr. Chairman: Fine. Thank you very much for your presentation. It was most informative, and we appreciate your coming.

Before the committee goes, I am not going to be here tomorrow. Jean Poirier is going to chair the meeting. As you know, we have an all-party agreement for extra time in the week of September 15, but we are going to let that hang. If we can finish with the consultants on Thursday and Friday, we may not require that time. We are going to leave it in abeyance and decide later in the week, but I want you to block it off in the meantime in case we do need it.

The committee adjourned at 5:07 p.m.

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SELECT COMMITTEE ON HEALTH

COMMERCIALIZATION OF HUMAN SERVICES

TUESDAY, AUGUST 26, 1986

Morning Sitting

SELECT COMMITTEE ON HEALTH

CHAIRMAN: Callahan, R. V. (Brampton L)
Andrewes, P. W. (Lincoln PC)
Baetz, R. C. (Ottawa West PC)
Cooke, D. S. (Windsor-Riverside NDP)
Johnston, R. F. (Scarborough West NDP)
Poirier, J. (Prescott-Russell L)
Polsinelli, C. (Yorkview L)
Reycraft, D. R. (Middlesex L)
Sargent, E. C. (Grey-Bruce L)
Stephenson, B. M. (York Mills PC)
Turner, J. M. (Peterborough PC)

Substitution:

Bossy, M. L. (Chatham-Kent L) for Mr. Callahan

Clerk: Deller, D.

Staff:

Fooks, C., Research Officer, Legislative Research Service

Witnesses:

From the Ministry of Health:

LeNeveu, R., Assistant Deputy Minister, Administration, Finance
and Health Insurance
Corder, D. W., Assistant Deputy Minister, Mental Health; Acting
Assistant Deputy Minister, Community and Public Health

LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON HEALTH

Tuesday, August 26, 1986

The committee met at 10:12 a.m. in committee room 2.

COMMERCIALIZATION OF HUMAN SERVICES

The Vice-Chairman: Shall we start proceedings this morning? We have a quorum with all three parties.

Miss Stephenson: We have one party and two others.

The Vice-Chairman: Thank you for your precision.

Will Mr. Corder and Mr. LeNeveu come forward, please.

Miss Stephenson: This is what was produced by the Ministry of Health. Ron LeNeveu is responsible for producing it. What he is trying to do is kill us with paper.

The Vice-Chairman: We appreciate very much that you gave us the pocket edition of your manuscript.

Miss Stephenson: This is the shorter LeNeveu version.

The Vice-Chairman: Where would you like us to proceed in this mammoth, earth-shattering work?

Mr. LeNeveu: If you open the cover and turn to the third page, there is an index.

Just walking quickly through the index, yesterday we touched very briefly on legislation, and we went through laboratory services and emergency health services. Basically, there are five major topics: mental health; dropping down to number 11 is alcoholism; number 12 deals with community health services, health service organizations in particular; and then there are hospitals and nursing homes.

I was talking to David Corder this morning. Basically, he will be making all the presentations because he has his own responsibility for mental health and has been acting in the community health area with the one exception being item 14, hospitals.

If you agree, Mr. Chairman, we thought we might try to touch on the highlights in terms of mental health, alcoholism and community health this morning; Randy Reid will come this afternoon to deal with hospitals; and then David will again be here in terms of nursing homes.

In talking to David this morning, he felt that perhaps it might be best if one were to focus on items 6, 7 and 8 because they deal more with the terms of reference of the committee, the psychiatric hospital system. Those other papers were put in as background to put a total framework around mental health with items 6, 7 and 8. Then we can perhaps deal more with the public-private sector question and item 11.

David thought, if that would be acceptable, he might try to touch on the highlights of items 6, 7 and 8 first, answer any questions you might have and then he would go to alcoholism, which is related but a somewhat different topic, and then perhaps go to number 12.

That way we probably could get through the highlights of the papers we have presented as background for you. Then this afternoon, as I say, we would deal with items 14 and 15.

The Vice-Chairman: Fair enough. The members of the committee are in agreement with this. Would you like to start?

Mr. Corder: As background information for items 6, 7 and 8, the approved homes, the homes for special care and the community mental health services program should be viewed in the context of being a conscious effort to deinstitutionalize the psychiatric patient and to reduce the inpatient beds in the provincial psychiatric hospitals. At the same time, there has been an increase in the beds in the acute general hospitals, but there has been a return of the psychiatric patient to the community.

The approved homes were first established in 1935. They were to provide a short-term, six-month traditional transitional living experience to teach patients practical community living skills in order to prepare them for return to more independent living in the community.

The homes are funded through the provincial psychiatric hospitals budget on a per diem basis. These per diems are paid to individual private operators who may make a profit. The operators are selected on the basis of their maturity and sensitivity to the needs of the mentally ill. Regular seminars on the care of the mentally ill are provided to the operators by hospital staff.

Additionally, the residents receive weekly visits from social workers who provide support and counselling. All homes must comply with local municipal bylaws and are inspected annually to ensure fire safety and environmental standards are maintained. In 1986, there are 160 places in approved homes for psychiatric patients, each receiving a \$12.88 per day for a total of \$1.2 million per annum.

The homes for special care program was established in 1964 and it operates under the Homes for Special Care Act. It is to provide nursing care and supervised accommodation in the community for patients discharged from provincial psychiatric hospitals and residents discharged from regional centres for the developmentally handicapped.

There are three levels of care provided through this province: extended care, where there is a minimum of 1.5 hours of nursing and personal care required per day; intermediate care, where the nursing care requirements are less than 1.5 hours per day; and then there is residential care in homes in the community.

Both the extended care and intermediate care are provided in licensed nursing homes and residential homes. Most of the residents are judged to have little potential for ultimate placement in the community because of their needs for 24-hour supervision and, in some cases, regular nursing care. Of the 467 homes for special care, nursing homes and residential home operators, 460 are operated for profit by individual operators or companies within the private sector. Only seven homes are operated on a nonprofit basis.

10:20

The homes for special care program is co-ordinated provincially by local field workers who are responsible for appropriate placement of residents, assessing perspective home operators, regular visits to monitor residents' wellbeing and authorizing expenditures on behalf of residents.

The Ministry of Health pays the homes for the residents' custodial care on a per diem arrangement. Additionally, the costs of comforts and kind, such as clothing and toiletries, are billed by the home operator to the ministry which reimburses the operator after authorization by the local field worker. Wherever possible, the ministry attempts to recover some or all of the expenditures from the residents' trustee. Actual expenditures in 1985-86 were \$87 million.

The annual fire safety inspection of the home is co-ordinated by the Ontario fire marshal's office, and follow-up inspections are completed as necessary. Environmental health inspections are conducted by the public health inspectors of the local health units on an annual basis with follow-up inspections as required.

The community mental health services program was developed in the recognition that there was a growing need for support for the mentally ill in the community. In response to this recognized need, the ministry established community mental health services in 1976, which is now labelled the community health services program. The program provides an administrative structure for the funding, monitoring and evaluation of community-based mental health services.

As a result of district health council reviews and its ongoing involvement with program staff, the following priorities have been established for community health services: programs providing service or supportive housing for the chronically disabled patient, programs for the aged, programs for women, programs to deal with those in psychiatric crises and programs for people whose language or culture hinders them from accessing assisting services.

At its inception in 1976, the community mental health services program funded 25 local programs. In 1986, the program provides funding to 273 community-based programs for those in need of mental health and services.

The types of programs include support of housing with supervision varying from one week to 24 hours a day, depending on the needs of the client group, co-ordination, case management designed to improve accessibility to services and to reduce duplication and fragmentation of services, a range of outpatient services specifically for the elderly with psychiatric problems, self-help programs in which former psychiatric patients provide mutual support and assistance, rehabilitation programs, vocational and social rehabilitation to prepare former psychiatric patients for employment and normal social interaction, and treatment programs which provide assessment, diagnosis, treatment referral and crisis intervention.

Community mental health service programs are sponsored and managed by private, nonprofit community boards. They are funded on the basis of an annual budget submission through the Ministry of Health Act. In 1985-86, \$42.9 million was expended on these programs. Each new program is funded for a two-year period during which time it is subject to an evaluation before a decision is made regarding ongoing funding.

Each program signs a memorandum of understanding with the ministry, detailing services, management structure, evaluation mechanisms, approved budget recording mechanisms and financial control systems. In addition, where the programs provide residential services such as housing, they must comply with local municipal group home and boarding or lodging home bylaws.

There have been a couple of exceptions to these usual administrative arrangements over the past few years. Dr. Reva Gerstein in Metropolitan Toronto and others in other municipalities have assisted the ministry in identifying the needs of discharged psychiatric patients living in boarding housing and rooming homes. A significant number of discharged psychiatric patients live in these homes because of the scarcity of low-cost housing. The ministry provided funds to upgrade the physical environment in boarding homes and to provide therapeutic services to the residents.

Community mental health services programs operated by private, nonprofit boards provide the programming to the residents. The physical improvements to the homes are funded by the Ministry of Health with funds flowing through the local municipality to private, for-profit boarding home operators.

Each municipality is responsible for the administration of funds associated with the upgrading of the physical property standards. The municipality disperses funds on a cyclical, interest-free or reduced interest rate, with repaid moneys being used to continue the upgrading of the additional boarding homes. The community mental health services program of the Ministry of Health is responsible for funding and monitoring the professional support services provided by local nonprofit agencies.

In 1983, a pilot project was established at Shannon Court in Parkdale in Toronto, a private boarding home that served discharged psychiatric patients. The ministry provided funds to cover the cost of staff to provide mental health programming to the residents in the home. The funding was tied to specific conditions regarding the number of residents, staff supervision and compliance with fire safety and health regulations, working towards specified ministry objectives within the two-year evaluation period.

This program did not meet its objectives, and a plan is now under way for Houselink Community Homes, a supportive housing program, to assume management of this home. At this time, Houselink plans to demolish the present structure and build several small homes on the site. Houselink is a nonprofit community agency.

In another, more successful project, Sherbanville boarding house, received funds from the Ministry of Health for staff to provide improved services to residents. Ministry staff have monitored the program, and the home has complied with all ministry requirements. Funding, therefore, continues to be flowed to this private boarding home owner.

That deals with the three items under the community mental health homes for special care and approved homes. Would you like to question me on that section?

Miss Stephenson: That is a natural division point.

There is a discrepancy in the figures you mentioned, Mr. Corder, regarding programs under the community mental health program. In several places in your presentation, the number is listed as 359.

Mr. Corder: That is correct.

Miss Stephenson: You suggested a figure of 200 and something. What is the difference?

Mr. Corder: The figure of 359 includes both the mental health community programs and the community addictions programs. There are 87 community addictions program and 273 community mental health programs.

Mr. R. F. Johnston: I have a couple of things; perhaps you may not be able to help me with one of them. What jumps out at me when I look at these programs is the hotchpotch of philosophy that seems to be behind them. You have homes for special care, which are primarily in the private sector, and you state they have been primarily unchanged in terms of program demands on them for the past number of years. You have the community programs for mental health patients, which are primarily run on a nonprofit basis, by the looks of the figures here. Then you have the boarding homes, which, again, are for profit and are now receiving money for upgrading, even though almost none of them has any program in them at all or any protection for the mentally ill.

How have we evolved into what seems to me to be an incoherent view of how these services should be provided, in terms of what should be provided privately and what should be provided in a nonprofit fashion? Why the distinctions?

Mr. Corder: I am afraid I probably cannot tell you philosophically why there are distinctions. The history of the programs I am trying to administer date back a long time. The 1935 initiative for the approved homes was a mechanism available at that time to purchase services to see whether people could live in the community. I cannot comment why they chose to use that mechanism at that time.

As the document indicates, there has been a decrease in the use of that kind of facility over the years. There are not a lot of people in the approved homes at this time. They are used for a very special kind of client. You will find they tend to use our nonprofit community-based programs for community support.

On the issue of housing stock, I do not believe the Ministry of Health has ever bought boarding homes and tried to run them. They have tried to use what exists. Honestly, I cannot philosophically answer your question.

10:30

Mr. R. F. Johnston: There have been reviews in the past number of years around community health programming and the alternatives to institutional care. What surprises me is that we have stuck with the range that is there, although we increased the community-based programming that is out there for people. We have maintained the options of the approved homes, the homes for special care and the boarding homes as the base. Has any work been done over the past number of years by various people in the ministry to try to rationalize that into a more coherent set of services? They do not seem to me to be coherent in terms of the quality of care requirements that are needed or in terms of who should be running what.

Mr. Corder: In terms of the quality of care, there have been several reviews. The most recent was the Touche Ross report that dealt with clinical

care in the homes for special care component. However, the reports that dealt with clinical care did not attempt to deal with the housing stock. They told us how to go about taking programs of mental health support into the homes. That has been the thrust.

The whole concept behind the homes for special care program was room and board. That is essentially what happened in 1964. Today we are taking steps to bring programming into those environments so that the people have some sort of quality of life in the community in which they live. None of the reports that I have read deals with the housing stock issue. They deal with the programming issue. That is provided by the community-based nonprofit groups.

Mr. R. F. Johnston: Looking at the program that is available in homes for special care, I am aware of the triministry project to try to provide individualized program for mentally handicapped individuals in those homes, primarily the younger ones. What has been the process in ensuring that there is individualized program for people who are not mentally handicapped, but who may be mentally ill, in the homes for special care? I am not aware of those.

Mr. Corder: There have been initiatives out of the provincial psychiatric hospitals because they are administered by the provincial psychiatric hospitals. However, you raise a point because the whole program was custodial in nature. That was the essence of the Touche Ross review. It was to provide advice as to how to take consistent programming into the homes for special care. That is being handled now by the Ministry of Health.

Mr. R. F. Johnston: I am not exactly clear about this. How many residents with mental illness are in homes for special care at the moment?

Mr. Corder: Off the top, I do not know. There are about 6,000. If you want, I can get you the breakdown of actual numbers.

Mr. R. F. Johnston: I would be interested because I know the figures for the developmentally handicapped. I am not sure how many now are other mixes or just older people who are there for custodial care, how many people who live--

Mr. Corder: I believe that information--

Mr. R. F. Johnston: I am just looking for it myself. Can you tell me what has happened in the great debate between the two ministries, Community and Social Services and Health, as to who should run homes for special care?

Mr. Corder: You are referring to the developmentally handicapped component.

Mr. R. F. Johnston: Yes.

Mr. Corder: We continue to have discussions. Actually, we are having some very good discussions right now about resolving that issue.

Mr. R. F. Johnston: So it is not completed. I will let other people in.

Miss Stephenson: The figure regarding the number is on the first page of the white part of tab 7. It is 5,578.

Mr. R. F. Johnston: Do we know that those are people who are psychiatric--

Mr. Corder: On page 2 of the set of tab 7, you will find that it says "facilities" about a quarter of the way down. There are 211 nursing homes. It says there are 3,548 residents, and the number of developmentally handicapped is included in that; likewise in the residential component.

Mr. R. F. Johnston: Does that necessarily mean that all the others are mentally disabled? We have talked a lot about the number of children--and I notice that is alluded to here--the developmentally handicapped who still remain within homes for special care. Are there any children at all who are mentally disabled?

Mr. Corder: Who are developmentally handicapped? Yes, I believe there are.

Mr. R. F. Johnston: No. I am talking about mentally ill.

Mr. Corder: I do not believe so. I believe they are all developmentally handicapped.

Mr. Andrewes: You described the approved home program as designed for short-term transitional rehabilitation service. In terms of the availability of beds in approved homes, numbers are dropping quickly. What sort of philosophy is driving that?

Mr. Corder: In the section I did not deal with, there are several paragraphs describing changes in approach to psychiatric care. With respect to the whole notion of custodial-type care, of getting people ready for community, with drugs, psychotherapy and new approaches to therapy, they do not need the kind of long-term institutionalization today that they did in 1935; so the numbers requiring it have decreased considerably. It is a whole change in philosophy of care.

Mr. Andrewes: The numbers requiring that adjustment period?

Mr. Corder: The approach taken at that time to try to get them able to live in the community can be realized quicker today with the therapeutic approach of drugs, psychotherapy, occupational therapy, workshops, group therapy and that kind of thing.

Mr. Andrewes: Are you telling me that the numbers are down considerably or the length of stay is down? What are you saying?

Mr. Corder: The length of stay in the provincial psychiatric hospitals is down.

Mr. Andrewes: Then they move directly into the community?

Mr. Corder: Directly into the community.

Mr. Andrewes: I want to pursue Mr. Johnston's point a little. The thrust of the Touche Ross report is that homes for special care are designed primarily for custodial care. What type of programming is offered to residents in homes for special care and who is offering it?

Mr. Corder: It is sporadic. It is not consistent across the province. There are different types of programming offered by the different psychiatric hospitals. It tends to be support. There is some counselling. There are some programs that the field workers arrange. These people may attend the community-based programs that exist in some of the communities. There is usually the monthly field visit by the social worker for some counselling. That is essentially all. It continues to be mainly a custodial program.

Mr. Andrewes: Are you concerned about the fact that they are sporadic and not consistent?

Mr. Corder: We are very concerned about programming for the discharged psychiatric patient in the community setting. This is one concern.

Mr. Andrewes: In terms of the homes for special care, is a differentiation made between the individual whose opportunity for rehabilitation and access to programs is better than someone else who perhaps will require custodial care for the rest of his or her life?

Mr. Corder: If I understand your question correctly, perhaps I have not made it clear that the clientele of the homes for special care, while they do need some programming supports which may well enhance the quality of their lives, tend to be people who require some supervised living situation for the rest of their lives.

Mr. Andrewes: For ever. What sort of program can you design? What sort of activities can they become involved in other than simply passing the time of day?

10:40

Mr. Corder: Maybe it is passing the time of day. Maybe it is some group work. Maybe it is community groups where they could go to some sort of workshop setting. Maybe it is a day kind of drop-in centre. It really becomes a quality-of-life issue. The individuals probably could be integrated into the community in a more positive way; however, they still would require, based on the criteria for admission to that program, some sort of long-term supervision in the living environment.

Mr. Andrewes: What responsibility does the home operator have for the program?

Mr. Corder: The home operator is responsible for providing 24-hour supervision and essentially for room and board.

Miss Stephenson: Are they not now responsible for permitting, encouraging, or assisting the introduction of programs into the home as well?

Mr. Corder: Yes.

Miss Stephenson: I thought that change had been made a couple of years ago.

Mr. Corder: Yes, they are responsible for that where it exists.

Mr. R. F. Johnston: It is not a global responsibility because--

Miss Stephenson: No, it is not universal.

Mr. R. F. Johnston: --there are whole regions of the province where it does not exist at all.

Mr. Corder: They are responsible for seeing that their residents avail themselves of the programs that are there or bring in the programs to the home if they exist. Many of the psychiatric hospitals have worked in conjunction with these homes to try to have initiatives in the communities.

Mr. R. F. Johnston: I have a supplementary on that. I remember two years ago when I asked for information about what programs were actually available in homes for special care for the developmentally handicapped, I discovered that in, say, the vice-chairman's area of Prescott-Russell, that none of the homes for special care provided any program at all. That was for the developmentally handicapped. Would it be possible to get a regional breakdown around the province about what homes are providing programs, the nature of them, as Mr. Andrewes is asking, and just to get an idea of how that is progressing at this stage?

Mr. Corder: Would it be all right to provide it by psychiatric hospital? They are administered in that configuration.

The Vice-Chairman: Are there any more questions?

Mr. Andrewes: Just one, Mr. Chairman. What qualifications is an operator of a home for special care required to have?

Mr. Corder: I use the words "maturity" and "sensitivity" in the approved homes. I guess you would apply that to the homes for special care as well. They are interviewed and there is an evaluation made about their ability to deal with the psychiatric patient discharged to the community. They have no formal academic qualifications.

Mr. Andrewes: In other words, if you were to take a person who you sensed had maturity and sensitivity, what else is required in a home? Is there nursing care required? Is there a registered nurse required?

Mr. Corder: Not in the residential component. You merely have to be in the home or provide someone in the home 24 hours per day.

Mr. Andrewes: Are the staff or is the home operator required to have any background in the use of the administration of drugs and drug therapy?

Mr. Corder: Certainly not in the administration of drugs, but they are taken into the hospital and given educational programs about the patient's use of the medication that is supplied by the provincial psychiatric hospital.

Once again, the individual operators are brought into the provincial hospital and given these sessions. That is consistent across the province--the educational programs offered to the operators. The support of the client in the normal home situation, that kind of education, is provided by each of the hospitals but they are not trained in any nursing procedures or anything like that.

Mr. Andrewes: Is the client responsible for following the prescription?

Mr. Corder: The client is responsible for following the prescription under supervision. Of course, if the supervision indicates that the clients are not following the regime that was set out, that is to be reported to the hospital, or if the condition is deteriorating, or if something seems to be happening that makes their behaviour not the same as it was when they arrived, they are supposed to go to the hospital.

Mr. Baetz: Mr. Corder has indicated that the homes are run by a mix of individual operators and companies. I think it was Mr. Johnston who called that a hotchpotch, which has a very pejorative ring to it. A mix can also be a beautiful buffet providing a broad selection. It is an orchestrated thing. You tended to skate away from that question, and I would like to come back to it.

I am not going to describe the mix in a pejorative way right off the bat or a priori, but in that mix of opportunities available for the patients, are there any trends? Is there a general impression that the commercial operator does a better or a worse job or that certain agencies or certain communities do better jobs? What kind of ongoing assessment is there? Is there an overall profile of the quality of service provided, quite apart from room and board? That is one of the basic questions this committee will be asking. Which is better, or are there pros and cons on both sides?

Mr. Corder: I have no opinion on which is better, but both kinds, for profit and not for profit, must meet the same standards. In the programs for which I am responsible, both types of programs meet the minimum provincial standards. I cannot say one is better than the other. They both meet what is required of them.

Mr. Baetz: In terms of the quality of the programs, you say they are the same. Your assessment is largely a quantitative measurement, I imagine. What criteria do you apply to meeting the standards? For room and board, it is fairly easy. Are the beds comfortable? Is the home warm? Beyond that, how do you measure the quality of the care you are looking for? Does the private operator tend to provide that minimum in order to make more money, or do you sense that the quality of care can be the same whether it is for profit or not for profit?

Mr. Corder: That is a very difficult question to answer. If you look at the residential component of the homes for special care, we purchase room and board from them; so I cannot comment on their operation other than room and board. The programming is provided by community-based mental health boards in not-for-profit homes. In that sector, I have never had to deal with for-profit agencies. I know only what the nonprofit can deliver.

In the area of boarding homes, I have given you two examples, a for-profit home that did not work out and one that did work out. We have only the two. I cannot answer in that way, but I can answer from a program point of view. When you are providing room and board, you meet the standards whether you are profit or not. I agree, in terms of room and board, the beds and the food are there, but from a programming point of view, we have not involved the for-profit sector in the community-based program approach.

Mr. Baetz: I have a slightly different question on the same subject. In regard to the programming the nonprofit groups provide, is any assessment ever made of how effective those programs are in reaching the clients they want to reach? They are dealing with a clientele in which the worst cases are often the most difficult to reach; they do not co-operate. Do you get any feeling that they are really reaching these people and helping them, or is

there an attitude that prevails, "We tried; our social worker was in and visited X homes and thereby met the criteria of the program"? Again, we are back to the quality of the thing. Is it harder to reach these people in this kind of setting than it would be if they were in a more organized--I do not want to use the word "institution"--setting?

10:50

Mr. Corder: The discharged psychiatric patient in some instances tends to be quite difficult to co-ordinate services for, but I am very impressed with the community mental health agencies and the types of clients they deal with. They are not all perfect, I realize that, but if you take a look at what has happened in Parkdale, you will see they really go out and try to do things with the most difficult people. Take a look at Progress Place in North York. Those clients are severely disabled, and that group opens initiatives. They really deal with difficult clients.

They are difficult to get hold of at times because some of them tend to drop through the slats or, because of their illness, some of them do not recognize that they need some co-ordination, but I do not believe the agencies themselves tend to stream. When they get difficult people, they deal with them. Some of them do fall through the slats, I agree with you.

Miss Stephenson: The group home was the item I wanted to raise with Mr. Corder. It seems to me there is an understanding now that although the length of time necessary for community reorientation of a discharged psychiatric patient has been reduced very dramatically over the past several decades, for many patients there is an absolute necessity for that kind of semi-organized approach to reorientation. It would appear from the experience we have had so far that the group home setting is a reasonable way in which to provide that. You have a responsibility for assisting in the provision of that service, at least accommodation and sustenance for those patients, because most of those patients are involved with a community mental health program. I think all of them are; none are denied that kind of program.

Is the group home program expanding satisfactorily? Is the progress sufficient, at least in the relatively near future, to meet the needs of the discharged psychiatric patient that can be perceived? There is no doubt in anybody's mind that keeping them in 999 Queen Street West or any of the other provincial institutions is not going to resolve their difficulties with respect to cure, support or improvement.

Mr. Corder: You have definitely identified the area that is the priority, the supportive housing notion, be it a group home or whatever other kind of support. One of the difficulties of going into the communities is that communities can support only so much at any given time. Getting the human resources into the communities to take care of the people has sometimes proved a bit of an impediment. I suppose you could say we are not moving as quickly as we could, but I believe we are moving as fast as we can for the communities to absorb the kind of stuff we are trying to get them to do. Maybe I am wrong.

Miss Stephenson: I do not think you are wrong; I think, in a way, you are right. It worries me at times that communities that obviously have the capacity at least to allow that kind of situation to take place are frequently very reluctant, and some of the most normal people, who I would have thought would have been generous in their approach, are absolutely cement-minded about opening up their own communities for that kind of support. When you have a group such as Progress Place, which has the capacity to develop more and knows

what its capacity is and what its limitations are, being stymied by some of my constituents, it is very disturbing.

Is there in this province at this time a totally privately funded institution or setting of any sort in which mental health services are delivered? We used to have them. Is there any such thing now?

Mr. Corder: I will have to check that when I go back, but I cannot recall off the top of my head that we have one like that. We have ones that are privately operated but also get public funds.

Miss Stephenson: That is not what I am talking about. I am talking about one that is privately operated and receives no public funds at all.

Mr. Corder: I cannot recall one off the top of my head. I can go back and check that out.

Miss Stephenson: We had a couple of them, one of which made significant progress for a time in terms of treatment and led the way for Ontario psychiatric hospitals. Then the Ontario psychiatric hospitals began to pursue the same course, and for some reason the province decided that kind of relative competition was not of value. I am not sure it decided that, but it sure as hell starved out the private institution completely. As a result, it is no longer private; it is a public institution.

Therefore, we do not have the opportunity to do the kind of thing I think you were suggesting in terms of the delivery of program within any kind of setting. The program that is delivered is always publicly supported. There is no privately supported program so we can compare whether there is a benefit one way or another. The decision was made a long time ago that we were not going to have privately supported psychiatric programs or full programs for the developmentally handicapped, which were provided by private sources until then.

However, I am curious to know if you can explore to see whether any innovative psychologist has developed anything.

Mr. Corder: I will certainly check that out.

Miss Stephenson: Okay.

Mr. R. F. Johnston: I am wondering whether this is one of those matters that falls among the responsibilities of the psychiatric institutions, the community programs and the home special care and other groups, and that is the whole question of the success of the mental health care system. We have often measured it by the fact that now there are shorter stays in psychiatric hospitals and that drug therapy, etc., has allowed people to leave hospitals. But as part of that process there has also developed what is known as the revolving-door syndrome.

What latest comparative figures do we have on the percentage of people who return to psychiatric institutions from community placements and so on? Can we see whether that has been diminishing and look at certain kinds of programs that seem to have been effective there or see whether there has been any change?

Mr. Corder: I will certainly get you the readmission rates, but I think it was Dr. Heseltine who pointed out that readmission rates are not

necessarily bad; any period you can support a person in the community is probably worth it, and that might mean they are admitted six times over a two-year period. It is difficult to judge the success of your approach on readmission rates, but I will get that for you.

Mr. R. F. Johnston: I agree with your comment. Do we have any information about readmission in terms of people who fell off drug control who were in supposedly controlled settings and that kind of thing? Is that information around to know where the system has failed radically?

Mr. Corder: I do not know the answer to that. I do not know if we keep it specifically by the clinical problem they ran into, but I will check and see.

Mr. R. F. Johnston: What I am really fishing for is to know whether the ministry has been doing any reviews of this to try to determine whether the readmission phenomenon has been a positive indication that kind of basic care, tertiary care, is required in the major psychiatric institutions as part of the backup or whether it has been a failure of the community programs to provide support.

Mr. Corder: I will look into that for you, but I will give you an example of the stuff I read in the literature. Most of the young discharged schizophrenics are not in our community-based programs; they are being cared for by families. It seems the medication issue is one thing that is a problem for them. When they decide they do not wish to take their medication, they become acutely ill. That is probably the same for the community-based programs as well. I will check into that.

11:00

Mr. R. F. Johnston: Is the percentage still the same for the number of people who go into the programs versus those who just go to home and family or wherever? You mentioned earlier in answer to Mr. Andrewes's or Mr. Baetz's question about the difficulty of follow-up after somebody leaves a psychiatric institution because of the civil rights involved in terms of not requiring care if you are no longer committed. I forget what the percentages used to be. About 80 per cent went home and 20 per cent went to the--

Mr. Corder: I understand. That is the figure in my head. I can check that for you. I do not have that with me.

Mr. R. F. Johnston: I am just wondering whether that has been shifting at all.

Mr. Corder: Not to my knowledge. I think that was also the figure Dr. Heseltine used.

Mr. R. F. Johnston: I think so too.

Mr. Andrewes: Going back to homes for special care, the inspection of these homes you referred to was primarily for fire safety. It is now done under the fire marshal's office and the municipal fire protection organization, whatever it might be. Is that the only inspection of the homes?

Mr. Corder: They are only inspected by the Ministry of the Solicitor General for fire safety and by the public health people to meet the environmental standards. They are visited by a field worker on a regular basis

to make some assessment of the residents, their needs, their comforts and that type of thing. Those are all the types of visits these homes have unless there have been programs in their communities that the owner accesses.

Mr. Andrewes: Is the field worker concerned for both the welfare of the patient and whether the home itself is providing the appropriate setting?

Mr. Corder: Certainly, in the first instance, they are the people who interview the home operators, talk to them about their home, have a look at it and that type of thing. I presume they are involved in that assessment on an ongoing basis. If they feel a resident is not taking food properly for whatever reason, be it his condition or whatever, they will do something about that.

The Vice-Chairman: You mentioned some figures a while ago about the proportion of private, public, private for-profit and private nonprofit homes for special care. Would you give us those figures again?

Mr. Corder: There are 467 homes for special care, of which 460 are operated on a for-profit basis and seven on a nonprofit basis.

The Vice-Chairman: If there are no more questions for the moment, Mr. Corder or Mr. LeNeveu may want to proceed.

Mr. Corder: I will deal with the alcohol and drug dependency programs as one group. As I go through my presentation, you will see that the acute hospital component of this is dealt with by the hospital sector. I will deal primarily with the community-based sector in this area.

The alcohol and drug dependency program operates under the administrative umbrella of the community health services program, but it remains as a distinct and separate entity. Most general hospitals in Ontario offer some addiction services, and others are provided in specialized hospitals such as the Donwood Institute and the clinical institute of the Alcoholism and Drug Addiction Research Foundation. The private sector is also active in addiction services with facilities such as the Homewood Sanitarium and Bellwood Health Services.

The services I have just mentioned are the ones that fall under the institutional sector, and Mr. Reid will probably be bringing some information on that.

To encourage a balanced system of both the institutional and the community service approach to this problem, the ministry has supported the development of more community-based addiction programs. These programs are operated by nonprofit community boards, and research evidence indicates these programs have been extremely effective for the majority of clients they serve.

Currently, we have 83 programs that received \$11.7 million in 1985. These programs include assessment, detoxification, day programs, counselling, case management, residential care and follow-up care. There are 149 beds in residential facilities available to clients in Ontario at no charge. The funding for the program flows from the ministry to the local boards running the programs, and the programs are monitored, administered and subject to the accountability procedures outlined earlier for the community mental health programs.

That is the general structure for the approach to the alcohol and drug

dependency programs that are offered by the nonprofit community-based groups. I will be pleased to answer any questions on that.

Mr. Sargent: How many detox stations are there in Ontario?

Mr. Corder: I am sorry; I do not know that figure. I would have to get it for you.

Mr. Sargent: I would like to see how many localities could get a detox. Was there not a fight about this?

Miss Stephenson: Yes. The concept of detox centres, however, was at the core of the battle because there was an argument about whether that was the appropriate place in which to attempt to dry people out.

Mr. Sargent: We cannot get one in Owen Sound.

Mr. Corder: On page 4 of this submission, under tab 11, 22 detoxification centres are identified across the province.

Mr. Sargent: Where is that?

Mr. Corder: On page 4 of tab 11.

Miss Stephenson: They are in various kinds of settings?

Mr. Corder: Yes. They would be all kinds of settings.

Mr. Sargent: What are the guidelines to get one?

Mr. Corder: A detoxification centre? It would have to be a demonstrated need.

Mr. Sargent: I live there; there should be one.

Miss Stephenson: Your hospital could be involved in developing a detox centre if it wished to do so.

Mr. Sargent: We tried to get one.

Miss Stephenson: That has been one of the courses. Community mental health organizations too have established some--

Mr. D. S. Cooke: Most of the groups that apply for grants and start community-based programs always mention 70, 80 or 90 per cent success rates. I am never quite sure what they mean by that, because I am not sure how much work is done to follow the individual and what length of time they are talking about for success rates.

How much work is done by the ministry when you are doing the ongoing funding to determine the success of these community-based programs? In some cases, I am not even sure I would call them community-based programs; some of them are getting so big I would call them institutions unto themselves. How much work is being done to determine how successful these programs are in tracking the patients and so forth?

Mr. Corder: As Mr. Reid can point out in the institutional sector, they have some very sophisticated evaluation protocols built into their

program proposals. In the community-based sector, they also have built into that two-year evaluation component some verification of the success rates. The 70 to 80 per cent rates that you read about indicate we are dealing today with a different type of person who has a dependency from those of, say, 10 years ago. If you look at the individual who has not got any of the supports left in his life, mainly that he is not working, down and out--on skid road essentially--their success rates are not anywhere near the 70 per cent or 80 per cent we talk about. We find that with the kinds of people who still have some supports remaining, whose families are partially intact and who still have some contact with an employer, the success rate is much higher.

11:10

Mr. D. S. Cooke: What kind of monitoring of these facilities goes on by the ministry, or is it just basically an annual review when budget time comes up? We have in this province everything from people who are concerned running these facilities to priests, to whoever is involved in the programs. Where is the guarantee for quality control?

Mr. Corder: An evaluation protocol is built into the program proposals submitted by the community groups. A project development officer is assigned to each program who helps them in the design and implementation of the program, monitors them during the first two years of operation and is involved in a very detailed evaluation of whether they get ongoing funding. They are subject to the same rigour as the community mental health programs.

After the two-year period, if they are evaluated as being reasonable and if they have been successful in meeting the needs of the client group, the project development officer meets them one or two times a year, not as regularly as during the first two years.

In addition to the budget submission that they must send in, program information comes in at that time. You can appreciate that we have not had a lot of experience with a lot of community initiatives in this area, so probably the--

Mr. D. S. Cooke: It seems to be the in thing now, though. More programs are getting funded across the province, and every community has groups that are applying for funding. It is certainly a growing area, and rightfully so; it is a major problem. Are there plans? I do not buy the 80 per cent success rate.

Miss Stephenson: That is over a two-year period. Of course you can buy it, but what happens after two years?

Mr. D. S. Cooke: I am not sure in the ones I have seen how many follow them for two years. Most of what I have seen is for six months.

Miss Stephenson: Or one year.

Mr. D. S. Cooke: Six months is a step in the right direction, but I would not call it a success if someone goes back to abusing alcohol or drugs after six months.

Mr. Corder: It is a very difficult area and it is one that is a problem in Ontario. As I said, the ones who have no supports left prove to be very different from the 70 or 80 per cent we talked about. On the basis of the

experience we have had, if you get involved in an employee assistance program and you still have some sort of connections with a work setting, family and that type of thing, maybe you fall off now and then; but there are checks and balances built in so that someone blows the whistle before you get into trouble again. Those employee assistance programs seem to be very good, and that is the kind of client who seems to get hooked up nowadays.

Mr. D. S. Cooke: There is no doubt that when Chrysler in my community says to somebody, "Either you go to Brentwood or you are fired, and we will pay for you to be in Brentwood," there is certainly a motivation to participate in the program and there is success.

Since this is an area where the ministry is spending a lot more money than it did a year ago and where it is certainly going to be spending a lot more in the next few years, I hope some sophisticated evaluation programs will be put in place to determine how successful they are and what the right size is as well. I see some of these programs getting so bloody big that I am not sure they have that component of a small community base that was one of the reasons they were successful before they got into these big operations. I do not know whether you have seen the one down our way, which is funded primarily through bingos and where the companies purchase on a per diem basis as well.

Mr. Sargent: It looks as though you are funding about \$15 million a year. You refer to 83 community-based programs with funding of \$15 million. Does that sound right?

Mr. Corder: Yes.

Miss Stephenson: That is only ambulatory patients. There is a considerable amount of money spent on the in-hospital or in-institution.

Mr. Sargent: On top of that.

Is there growing separation in the area of drugs? Is that a different treatment from alcohol?

Mr. Corder: It is not. It is certainly an addiction. One of the problems faced by the programs today is cross-addictions. Although you hear people talking about alcoholism, it tends to be alcohol and something else a lot of the time today. A lot of the hard street drugs out there are problems for the young people. There is also a problem with the use of alcohol and prescription drugs. The programs usually tend to deal not only with alcoholism but also with some other drug.

Mr. Sargent: Under the same umbrella.

Mr. Corder: Yes.

Mr. Sargent: This may be a silly question, but is there any funding or are there tax incentives available to liquor firms to fund the programs? Do Seagram and those guys kick in any money to these funding stations?

Mr. Corder: I do not know the answer to that. I could find out for you. I do not know whether any initiatives have ever been made.

Mr. Sargent: Some members of the committee might see whether there is any merit in giving tax incentives to the breweries and the distilleries, if they would--

Mr. D. S. Cooke: If we give them tax incentives, we are still paying for it. If they do not pay the tax and we give it to them, we are still paying for it.

Mr. Sargent: We could channel that money into that. Will you check and see why we cannot get a detox in Owen Sound then?

The Vice-Chairman: I appreciate your part in the questioning, Mr. Sargent. Any more questions?

Mr. Reycraft: I am interested in learning a little more about what we are actually getting for the \$11.7 million that is being spent on the 83 programs. Do you know how that is divided out? How much goes for accommodation and how much goes for staffing?

Mr. Corder: I could probably go back and analyse it that way because we have all the budgets, but I do not have that information with me here today.

Mr. Reycraft: Do you know how many people are involved in delivering the service in the 83 programs?

Mr. Corder: No, I am sorry. I will have to go back and get that information for you.

Miss Stephenson: Do you mean how many clients or how many staff?

Mr. Reycraft: Staff. Do you know the process that is followed in getting funding for the additional staff required for various programs? Is that done on an individual program basis, with each application looked at and reviewed and recommendations made, then final approval or rejection?

Mr. Corder: It is done on an individual application basis and it is also done on advice from district health councils.

The Vice-Chairman: Miss Stephenson?

Mr. Reycraft: Go ahead. I can come back to it.

Miss Stephenson: No. Complete your questioning.

Mr. Reycraft: Can you tell us how much funding was requested or recommended by the district health councils for 1985-86 and how that compares to the \$11.7 million?

Mr. Corder: I cannot tell you off the top of my head, but I can get the information.

Mr. Reycraft: Do you know whether there would be a large difference?

Mr. Corder: District health councils tend to recommend large numbers of programs in all areas.

Mr. Reycraft: Then they prioritize.

Mr. Corder: They put them in priority. In the alcohol programs over the past several years, particularly last year, we were able to handle all the number one priorities. In some areas we handled more than the number one where there were large population bases.

Mr. Reycraft: Number one priority in terms of the total needs recommended by the health council or just for this type of treatment?

Mr. Corder: Of the recommendations relating to dependency programs. They send in lists of priorities for everything, hospital programs, community-based programs, dependency programs and other kinds of programs.

Mr. Reycraft: Thank you.

11:20

Miss Stephenson: I wonder, Mr. LeNeveu, whether at some point we can have the figures related to the amount of money that is being expended by Ontario in the matter of the referral of addicted patients for various kinds of addictions to institutions and programs outside Ontario and how that compares to the total amount of money being spent in Ontario in attempting to deal with this problem both in a clinical setting in institutions and in the community. It is my understanding that at present several thousand patients are referred on an annual basis to institutions, primarily south of the border, at very significant cost. I would like to know whether that is decreasing or remaining the same. If it is remaining the same or if it is increasing, why are we not doing something about it?

Second, I would like to know whether significant activity has been undertaken in the health education co-ordinating committee to ensure that appropriate training is being given in some educational institution in Ontario to provide the appropriate background for long-term follow-up, which is absolutely essential in the treatment of addiction. I think the treatment consists of lifetime follow-up, because if you are truly an addictive personality, you cannot change your personality. All you can do is learn mechanisms to deal with it effectively. The most important feature of so-called cure or improvement in this area is related to the appropriateness, validity and success of the follow-up program.

Mr. Corder cannot tell us a hell of a lot about the community programs because they have not been in existence long enough to tell us whether they are going to be successful in five or 10 years. They do not know at this point. However, those that have been in place for some time have demonstrated very clearly that it is the follow-up that is important. To my knowledge, we do not have at present, except in one nursing program in Ontario that has a somewhat embryonic program in development, the kind of capacity to ensure that all these community programs have the kind of people in them who are going to be effective members of the team to ensure the success of the program.

I would like to know where the program is that we are said to have at present and what its quality is in terms of the assessment that has been carried out by those who have some capacity for doing this.

The Vice-Chairman: Are there any further questions? If not, would you like to proceed, Mr. Corder?


Mr. Corder: I am going to deal now with the community health service sector beginning with the health service organizations and the community health centres.

The earliest expression of health service organization, or HSO as the acronym, was the community health centre, the CHC-type programs in Ontario, found in a multi-speciality group practice that began in 1963. The Group

Health Centre in Sault Ste. Marie was a union-initiated, community-sponsored plan, competing in the private insurance system.

Following the precepts of prepaid group practice in the United States, which later became known as the health maintenance organizations, their intention was to emphasize ambulatory care services using savings from control of inappropriate hospital utilization to offer a competitive benefit package to potential subscribers.

Throughout the 1970s, much attention was directed to the potential development of funding for medical and other health care services on a basis other than the traditional fee for service. A number of pilot program initiatives were started under federal, provincial and private auspices, pilot programs that the Ministry of Health assumed responsibility for in 1973. Early approaches included simple per capita funding arrangements for the larger-scale organizations, HSOs, with an identifiable patient population such as in Sault Ste. Marie. A salary-plus-overhead-formula approach was used to support the smaller projects, namely, the community health centres, many of which had grown out of a community movement in the 1960s.



During this early developmental phase, it was expected that the smaller CHCs would eventually grow and stabilize to the point that per capita funding might be appropriate. Throughout this period, the HSOs and CHCs were viewed as experimental. Indeed, it was not until 1983 that the programs were considered to be a permanent aspect of the health care delivery system.

CHCs are considered legitimate in their own right, rather than as organizations that will eventually grow into per capita funding, like an HSO. It has become apparent that both types of organizations have developed unique characteristics and approaches to the provision of primary care.

Simply put, the basic thrust of HSOs is to achieve more effective and efficient use of health resources, primarily through reduced use of health resources. CHCs have tended to focus on improving access to primary health care for groups with a higher burden of ill health, groups with higher health risks or groups lacking sufficient access to primary health care services.

The program objectives for HSOs and CHCs are, first, to create an environment that is supportive of physicians and other health care personnel and that allows flexibility in responding to the health care needs of the population they service. Second, they are to develop a co-ordinated system of health care delivery, which makes the most appropriate use of health care resources and which is accessible, efficient and economical, and provides special attention to health maintenance and illness prevention measures, which will enhance the health status of the population served and decrease institutional health care by giving emphasis to ambulatory care, self-care and home care.

I will now deal with the health service organization.

Mr. Sargent: What page are you on?

Mr. Corder: I am reading from notes.

Miss Stephenson: He is not on any page.

Mr. Sargent: Oh, I see.

Mr. Corder: It is tab 12.

The Vice-Chairman: Page 5, tab 12.

Mr. Corder: Page 5. I am dealing now with the health service organization. There are three types. There is the provider model, which is owned and operated by physicians in a group practice. There are 18 of these. There is the community-based model, which is a nonprofit corporation, association or hospital managed by a board of trustees nominated and elected by the enrolled members or community. There are three in this type of model. Then there is the family practice unit, which is sponsored by a health science centre and physically located in a hospital or the community. There are four of these.

Sponsors contract with the Ministry of Health to provide specified medical and health care services and personnel to an identifiable and voluntarily enrolled patient population. HSOs encompass both general practice and other medical specialties, depending on the size of the roster population served. The typical HSO has two medical specialists; the largest has 11.

HSOs receive capitation funding for the medical specialists they have contracted to provide to each enrolled member. The capitation amount is based on the average OHIP billings, weighted for age and sex, in the respective medical specialities. The per capita payments are adjusted to reflect the age and sex composition of the enrolled patients. The per capita payments currently range from about \$9.50 per month for general practice only to about \$19 per month for a full range of specialities. That figure is unadjusted for age and sex.

The adjusted per capita payments are earned without reference to the amount of service rendered, unlike the fee-for-service reimbursement mechanism. Roster verification processes are in place to ensure the accuracy of enrolled patient lists. HSOs have detailed procedures in place to monitor their rosters on an ongoing basis.

To ensure double payments are avoided, system-wide service utilization for each enrollee is continuously monitored through our OHIP payment system. Capitation payment is withheld or, in the jargon, negated during any month for enrollees who receive medical health services outside the HSO if the HSO has contracted to provide the services in the first instance.

11:30

In addition to per capita payments, HSOs are eligible to participate in the ambulatory care incentive program, which was first developed in 1979. This program is designed to encourage more appropriate use of limited acute hospital resources. In the ambulatory care incentive program, payment is made if the HSO has acute hospitalization rates per 1,000 of its enrolled patients that are less than the similar rates for the district, county, regional municipality or metropolitan area, whichever is the appropriate boundary in which the HSO is located.

Like per capita payments, acute hospital utilization rates are weighted to take into account the utilization differences resulting from age and sex. Program-wide HSO hospital use costs are equal to or lower than the provincial hospital use in all 12 of the age-sex categories where comparative hospital use was measured. In 1984-85, HSOs demonstrated an overall reduction of 16 per cent in the use of acute hospital days by the HSO patients when compared to a similar age-sex, geographic area, fee-for-service population in Ontario. Sault Ste. Marie, with more than 4,000 patients and 11 medical specialties, reduced hospital use by 22 per cent compared with the rest of the Algoma district for the same period.

The payments to HSOs for 1985-86 totalled \$23.6 million, \$20.8 million per capita and \$2.8 million for the ambulatory care incentive program. Individual HSOs range in size from 2,200 patients with two physicians providing general practice to 43,200 patients with 33 physicians providing general practice and specialty programs. Ontario's HSOs collectively serve about 180,000 patients.

The community health centres are the other alternative funding model for the provision for physicians' services on a fee-for-service basis. Special priority is often given to the frail elderly, the disabled and groups with geographic, cultural or linguistic access problems. CHC objectives resemble those of HSOs but are characterized by more affiliations with community and social service agencies and in meeting the health needs of disadvantaged subsections of the population.

Service populations are often of a highly transient nature. CHC sponsorship is limited to nonprofit agencies sponsored and operated by community boards, and funding is based on program-based budgets negotiated annually with the ministry. Physicians and other health care providers are employees of the community health centre. Unlike HSOs, CHCs do not draw from existing medical practices, but they must develop an assessment of need for their community and seek ranking and endorsement from their district health council.

A description of the Parkdale Community Health Centre, established in 1984 under the new program guidelines, provides an illustration of the CHC program model. This CHC is currently providing primary health care to approximately 1,800 patients in a depressed urban area of Toronto. The needs assessment carried out prior to establishing the centre identified four target groups towards which specific health programs would be aimed: the single-parent and economically disadvantaged family, older adults, workers exposed to occupational health and safety hazards and cross-cultural programs for new immigrants.

In providing these targeted health care services, the Parkdale Community Health Centre is closely tied to a wide variety of community resources. Parkdale currently maintains active liaison in planning joint programming and cross-referrals with some 40 other local agencies. These broad health care programs are organized around a core of primary care services, which can be provided in nine languages.

Unlike the HSO, the CHC's medical services are limited to general or family practice. There are currently 12 CHCs serving a patient population of about 42,000 at a total annual cost of \$4.5 million.

Mr. R.-F. Johnston: I am a member of an HSO. I hurt their budget because I am fairly actively involved in medical treatment. In terms of its budget, I am not a good person to be on an HSO.

I have been a little concerned. We tried to set up a community-based one. The doctors were quite interested in doing that, but even with an HSO we were starting off with a roster. It was very much more difficult to try to establish a community board approach and identify specific community needs than it was to let the thing go off doctor-based. That is how it is beginning. It is the Main Street one that has opened recently.

My question is how to encourage their development around community boards. If you try to set up a CHC, you have to be concerned about the number of doctors who are already operating in an area. It is not to take away from that; they have to target specific needs, even though it is a very difficult thing to do in advance. Can you provide us with the actual guidelines for application for CHCs or HSOs so we can perhaps see a little about the difficulties and try to think of some solutions to overcome them? Has the sort of thing we ran into been the problem for other groups?

Mr. Corder: To answer your first part, there are guidelines, and I will see that they are made available. Not all communities are supportive of the concept, and some communities do run into difficulty. With a CHC, one has to do a lot of the legwork to try to identify where it should locate appropriately and what kind of groups it is going to serve, whereas with a HSO one already has some sort of a base from which to work. They would be different in that respect.

Mr. R. F. Johnston: It is possible to evolve into a community-based HSO from a doctor-based one as the roster develops? One of our problems was how to provide extra services even if we have targeted them. For instance, there was a desire to do some prenatal work identified in our area, but we did not know whether we had the economic capacity to do it until we developed the roster more. We were not sure how many would come with the doctors. Is it possible to evolve into a community-based organization?

Mr. Corder: I have never been asked that before, but I do not see any impediment to that, if you have agreement of the people who are currently practising and providing a model and if they wanted to move to something else. I have never been asked that before. I can go back and read the book to see whether that is permissible. I can check that for you.

Mr. R. F. Johnston: The total number involved in HSOs is 180,000. How many did you say for the CHCs?

Mr. Corder: There are 42,000 patients under the CHCs.

Mr. D. S. Cooke: Why is it that with CHCs you take the approach that if there are adequate numbers of doctors in that community, another alternative method of health care delivery cannot be established? We do not have one in my community. There are only 12 in the province. Obviously, most communities do not have access to this type of health care delivery.

Mr. Corder: I am sorry if I left you with the impression that if there is enough whatever in a community, this cannot be looked at. There is a need component to it that a community group has to go out and identify if it is not to be something that is going to be set up that will completely destroy the fabric of the health care system already there. There is a need for this kind of thing by the kinds of groups identified that currently do not either access appropriately or are not being provided care.

Mr. D. S. Cooke: Some would say that the fee-for-service delivery of health care does not meet the needs of a lot of patients and you would not be destroying a lot by putting a CHC in its place and trying to build it up in a community. Does the ministry see the development of CHCs only as trying to fill a vacuum if it exists in a primarily low-income area or an underserved area, or do you see it as another alternative to the fee-for-service system that should be developed?

Mr. Corder: We see it as an alternative that should be developed in communities if there is a need for that kind of thing. If the community will not buy into the concept, there is no point in putting it there because it will not be used. There has to be some community acceptance of that notion before you can move ahead. That is what the Parkdale example clearly demonstrates.

11:40

Mr. D. S. Cooke: Parkdale is the most recent one that was set up, but a number of other communities were waiting for approvals. I gather the one in Windsor has been approved at least for the \$150,000, but what other communities are waiting for approval?

Mr. Baetz: Ottawa.

Mr. Corder: I believe we have several. I could find out the number for you.

Mr. D. S. Cooke: You said the community has to accept them and there has to be that community initiative. There have been community initiatives, but the ministry has never seemed to be terribly supportive in rushing into supporting any of these CHCs. I think the program would probably expand quite rapidly if anyone could see that the ministry was going to fund them. They have to wait a long time before the ministry even considers the proposals.

Mr. Corder: I will check and see how long they have to wait. In my few months in this area I have not been told by anybody or read anything that says we are actively discouraging these things. It is an alternative payment mechanism that we are very interested in. I have been involved in the one you have alluded to, Windsor. I am not aware that anybody is dragging their heels on approval of any of them. They are new, they require a lot of review in trying to establish the base from which to make the approval, but I am not aware that anybody is dragging his feet, but I will check into that.

Mr. D. S. Cooke: It is not a matter of dragging feet. It is a matter of a number of communities that have been waiting for a long time and we have heard lots of rhetoric from them. I guess it is more of a policy question. We have heard lots of rhetoric from Ministers of Health over the years that they support CHCs, but the program is not growing. There is Parkdale and there have been one or two others over the years. Twelve CHCs can hardly be called an integral part of Ontario's health care system at this point.

Mr. Sargent: I know the members in the Toronto area know a lot more about this than I do, but it is a revelation to me that we have a service here that is almost mobile, that is streamlined and that has an outreach factor. I think it is wonderful that this is going on. Could this be in tune with the trend to keep more patients at home by having this service available and keeping them out of the hospitals?

Mr. Corder: Certainly the notion of avoiding institutional-type care is part of the notion of the HSOs, particularly in that incentive payment. The CHC is a primary level of care, and presumably that has some impact on institutionalization. The whole system today, though, seems to be attempting to keep people out of hospitals.

Mr. Sargent: You are adapting to the marketplace. I think it is a great idea.

Miss Stephenson: At 43 Forest Avenue in Hamilton there is what appears to be a CHC and at the same address what appears to be an HSO, both physician-sponsored. I am curious about whether the HSO is going to become a CHC or the CHC is going to become an HSO, or whether they are going to continue to function in these two similar patterns at the same place and at the same time with probably very much the same people, since they are both involved in general practice only.

Mr. Corder: May I get back to you with that?

Miss Stephenson: You may indeed. I am just a little curious that this has happened, because a couple that started out as community health centres have become health service organizations, and I understand that the rationale for that was really very valid. Why do we have those two things side by side at the same address?

Mr. Corder: I will attempt to get you rational reasons for it.

Miss Stephenson: Fine. The other question I have--and I am not an economist and therefore would probably have difficulty in understanding this--relates specifically to the way in which the weighting is done, which ensures that the statistical information which is developed related primarily to HSOs is indeed valid when compared to that of a community with a similar population.

I was involved in the development of the Sault Ste. Marie clinic, I can tell you, and it was not without trauma that I was involved in that at the time. That was a long time ago. There have been continuing difficulties. You know and I know that for many years there was potential duplication. In fact, there was significant duplication of payment for the in-hospital services which were provided for the clients of the HSO at Sault Ste. Marie but were not subtracted from their capitation fee. There are still reported differences of opinion regarding the statistical information that is elicited from that group in comparison with the remainder of the community, since the group tends to be specifically age delineated and therefore less likely to be requiring certain degrees of hospital care.

Obviously, when you look at Kaiser-Permanente and others, which have a very marked age delineation, the comparison is almost impossible if you are going to examine the effect of other patterns. But the members of this committee should know that the physicians of Ontario have been supportive of various mechanisms of delivery of health care for more than 20 years. They are not opposed to the establishment of HSOs. In fact, that is why most of them are physician-sponsored rather than anything else. But they have been attempting to ensure that there is a variety of mechanisms available in order to provide the kind of variety, because some people love HSOs and others hate them; some love CHCs and others hate them; some love fee for service and others hate it.

Mr. Sargent: How long has this been in service?

Miss Stephenson: The HSOs? It is 23 years in Ontario. We started out with one very large one and then developed yet another very large one, which has since died totally, with the same kind of sponsorship that--

Mr. Sargent: It is mostly in metropolitan areas, though.

Miss Stephenson: Sharbot Lake sure as hell is not a metropolitan area, and there are lots of them that are not in metropolitan areas. They are in small communities and they began--

Mr. Sargent: But the unit costs, the patient costs, are way down.

Miss Stephenson: No, not necessarily at all. In some small communities, where there was a real problem in organizing, the communities were responsible, as Mr. Corder said, for getting together and developing a kind a program that could be acceptable to the Ministry of Health, and then attracted health service workers to come in to support it; so there are all kinds of approaches to the development.

Mr. Sargent: But the mobility of it is important too.

Miss Stephenson: I am not sure what you mean by mobility, Mr. Sargent.

Mr. Sargent: If you go into an area where you have--

Miss Stephenson: If you go into an underserviced area to provide health care professionals, you are going to provide the same kind of thing no matter which way you do it. Does it cost more way than another? I do not know. You would have to compare it with Bill Copeman's figures for the underserviced areas.

Mr. Sargent: You can set up a unit a hell of a lot more cheaply than you can set up a hospital.

Miss Stephenson: These things are not hospital-dependent at all. This is primarily to develop ambulatory care programs for patients throughout the province and to meet the kinds of requirements that, I have to tell you, are primary physicians' roles as well, which include preventing, if possible, the utilization of expensive hospital and institutional care.

The Vice-Chairman: Are there any more questions, Miss Stephenson?

Miss Stephenson: No.

The Vice-Chairman: For your fears of not being an economist, you did pretty well.

11:50

Miss Stephenson: I am not aware of the ways in which that weighting can take place so that you get the appropriate kinds of results that are not weighted in favour of one or the other.

Mr. Baetz: It is obvious from the information that we have here and the information we have that we were aware of in community health centres that the growth of these centres, whether they are health service organizations or community health centres, is not a major thrust of the health care development or health care delivery system in Ontario.

Mr. D. S. Cooke: Stymied by Tory governments.

Miss Stephenson: As a matter of fact, you are absolutely wrong, David, but go ahead anyway. That is not unusual.

Mr. D. S. Cooke: That was a predictable response, Bette.

Miss Stephenson: You always think my responses are predictable. I think you should call time out for an in.

Mr. Sargent: I agree with you, Reuben.

Mr. Baetz: Unlike the partisan interjection by my colleague from the NDP here, I do not think it has been part of political philosophy to cut back on this or halt the growth of the CHCs. In Ottawa, where we have three centres, all very successful, we desperately want another one. I have been asking the question, why are there not more in view of the fact that these are a successful way of providing health care services? I sometimes hear that from the street workers as it were or from others. I am glad to hear my colleague the doctor say it is absolutely not the policy.

Miss Stephenson: No, the policy--

Mr. Baetz: It is the medical establishment that is not too committed to the idea. They think it has a lower priority than some others. I would like to hear why it is that we do not have more growth in this area. You hear the people who are interested in the community health centres--the hospitals, for example--are not too interested in seeing the development of the CHCs. I do not know if it is true or not. I just pass on that I keep hearing this. You sometimes hear that some members of the medical fraternity are not committed to the idea.

Miss Stephenson: Sure there are lots of them not committed to the idea. A lot of citizens are not committed to the idea.

Mr. Baetz: Except the people who are involved with it or the communities where they operate out of are very happy with the CHCs. I am asking why that is because in Ottawa we have several. We have had a substantial growth in the area, but there are many communities where there are none at all. Why is it? What are we to look forward to?

Mr. Corder: I do not think I can provide you with the answer to why it is that way. The whole notion of getting community acceptance is very complex as you can realize by what we have tried to do in mental health with the public relations program, changing people's idea about traditional patterns of delivery and that type of thing. How they access the systems is sometimes not easy.

I think these ultimate payment mechanisms are not being discouraged. I think as we become more sophisticated in trying to handle the proposals that come in and maybe in understanding how to work with communities better, maybe we can get them approved quicker than Mr. Cooke has indicated we are doing right now. I do not think there is any conscious mechanism in place to try to thwart these initiatives.

Mr. Baetz: For example, when I say it seems to have a lower priority than some of the other areas of growth in the health care system, I am told your district health councils, for example, tend to give this a third or fourth priority. I do not know, but that is what I am told. Sure, they recognize the importance, but there are other areas that they think are more important.

Mr. Corder: I cannot comment on all the district health councils, but I know of the ones I have personally seen over the past few months, they have treated these kind of proposals as independent initiatives and have handled them separately from, say, the hospital proposals or other community proposals. I will check all the other ones to make sure they are doing it the same way.

Mr. Baetz: Implicit in that very approach of the district health councils in dealing with this growth is the idea that it is on the periphery of the thing, and once we have looked after the other more important needs, then we can develop these community health centres further.

Mr. Corder: That is not the philosophy. I will make it clear to the district health council through that program that this is not to be considered a poor sister kind of thing. It is a major component of the whole system and it has to be viewed as such.

The Vice-Chairman: Do you have any more questions, Mr. Baetz?

Mr. Sargent: I move we adjourn.

The Vice-Chairman: Would you like to adjourn or start another section?

Mr. Corder: I was not planning to deal with number 11 as an initiative in the context of your terms of reference. Is it 11 or 13? It is the one on the home care program. It is part of 12, but it is identified as number 13. It was a community initiative. The paper is in that section as information. If anybody has any questions later--

The Vice-Chairman: Fair enough.

Mr. R. F. Johnston: We probably will want to come back.

Mr. D. S. Cooke: Yes. Is there not a direction in some communities that some of the components of the home care program are in the private sector?

Mr. Corder: There is a very small percentage. I believe it is less than four per cent.

Mr. D. S. Cooke: With the expansion of the homemakers program and the integrated homemakers program, will that not be a major issue?

Mr. Corder: A larger proportion of the homemaker program is in the private sector. I can deal with it if you like.

Mr. R. F. Johnston: We do not need to deal with it now. I was thinking that the potential evolution of the home care program into the private sector is there, as is the homemaker side of things. It is something that we as a group will need to think about as we go along.

The Vice-Chairman: Did you want to have a look at it at two o'clock this afternoon or what?

Mr. R. F. Johnston: No. The briefing notes on this are fine at the moment. Later on, we will probably want to deal with it. I do not have any questions coming out of what is here. It is not something that we are going to want to look at.

Mr. Corder: The briefing notes on home care are very extensive and comprehensive on the issue of the homemaker.

The Vice-Chairman: What will you start with at two o'clock this afternoon?

Mr. LeNeveu: Hospitals. Randy Reid will be here this afternoon on public hospitals. Hospitals and nursing homes will be approached primarily from the institutional side this afternoon.

The committee recessed at 11:53 a.m.

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SELECT COMMITTEE ON HEALTH

COMMERCIALIZATION OF HUMAN SERVICES

TUESDAY, AUGUST 26, 1986

Afternoon Sitting

SELECT COMMITTEE ON HEALTH

CHAIRMAN: Callahan, R. V. (Brampton L)
Andrewes, P. W. (Lincoln PC)
Baetz, R. C. (Ottawa West PC)
Cooke, D. S. (Windsor-Riverside NDP)
Johnston, R. F. (Scarborough West NDP)
Poirier, J. (Prescott-Russell L)
Polsinelli, C. (Yorkview L)
Reycraft, D. R. (Middlesex L)
Sargent, E. C. (Grey-Bruce L)
Stephenson, B. M. (York Mills PC)
Turner, J. M. (Peterborough PC)

Substitutions:

Bossy, M. L. (Chatham-Kent L) for Mr. Callahan
Wiseman, D. J. (Lanark PC) for Mr. Turner

Clerk: Deller, D.

Staff:

Fooks, C., Research Officer, Legislative Research Service

Witnesses:

From the Ministry of Health:

Reid, R. H., Assistant Deputy Minister, Institutional Health
Corder, D. W., Assistant Deputy Minister, Mental Health; Acting
Assistant Deputy Minister, Community and Public Health

LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON HEALTH

Tuesday, August 26, 1986

The committee resumed at 2:06 p.m. in committee room 2.

COMMERCIALIZATION OF HUMAN SERVICES
(continued)

The Vice-Chairman: Shall we start, ladies and gentlemen? Welcome again, Mr. Corder and Mr. Reid.

Miss Stephenson: Mr. Hospital.

The Vice-Chairman: Mr. Hospital, yes. Would you like to start your presentation, gentlemen?

Mr. Reid: My presentation will apply to the acute and chronic care hospitals, which are those funded under the vote known as institutional health. The psychiatric hospitals have been dealt with by my colleague to my left.

The modern hospital system in Canada has evolved from a tradition of voluntary community commitment and philanthropy in which local benefactors, either alone or in conjunction with municipalities, financed the construction and operation of the institutions for their sick. In the early days, patients were hospitalized in either large, multi-bed public wards or private rooms, based on the patient's ability to pay. Private insurance schemes began to be made available in Ontario as early as 1912. Beginning in 1947, Ontario began a system of providing grants for hospital construction. In 1959, the Ontario government introduced full hospital services insurance.

By 1972, both hospital and medical insurance coverage were provided under one comprehensive health insurance plan, now referred to as the Ontario health insurance plan. This scheme ensured universal accessibility of health services to the people of Ontario and provided the basis for the comprehensive funding of hospitals.

The hospital system in Ontario is essentially a private one, consisting of two separate components: the private, not-for-profit sector, which we refer to as public hospitals, so as not to confuse them with the other, the private for-profit sector, which we refer to as private hospitals.

Public hospitals are by far the largest group, composed of 222 public hospitals, 14 crippled children's centres and two adult rehabilitation centres. Each of these is an autonomous, not-for-profit organization, incorporated and run by a board of governors who are responsible for the general management of the hospital in accordance with the Public Hospitals Act and its regulations. The statistical outline is on page 2 of my brief. There are 194 acute care and 28 chronic care hospitals. There are 168 lay corporations, 16 municipally owned hospitals and 38 charitable hospitals, mostly religious.

In addition, there are 17 private hospitals, owned and operated by either an individual or a corporation. There are no chains of private hospitals; they are all single facilities. They operate under the authority of the Private Hospitals Act, which outlines the conditions and requirements under which they may be licensed and how they shall operate. The minister has the power to review, transfer or revoke licences and approve alterations or renovations. Inspection is undertaken by the ministry staff to ensure standards of care and compliance with the legislation.

Six of the 17 hospitals provide acute treatment, usually of a specialized nature; two provide psychiatric care; and the remaining ones provide long-term chronic care. They range in size, from the largest, the Homewood Sanitarium in Guelph with 312 beds, to a four-bed traumatic and restorative surgical unit in Toronto. All the private hospitals provide insured services and receive their funding from the Ministry of Health with the exception of one institution, the Cosmetic Surgery Hospital in Woodbridge, which provides uninsured care and therefore is not funded by the ministry. It is licensed and inspected. The private hospitals operate on a for-profit basis. However, their profit level is restricted and allows only a 6.5 per cent return on invested capital.

In recent years, there has been a policy on the part of the ministry that ownership of the hospital system shall be in the public domain. This is reflected in the fact that no new licences have been issued since 1973, which is when the Private Hospitals Act was amended. On page 3 of the brief, there is a statistical analysis of a number of private hospitals in Ontario since 1969. There were 39 private hospitals in 1969 and there are now 17. There has been a deliberate process of attrition. On page 4--I will not read them all--there is a list of the acute and chronic private hospitals that were in operation in 1969, but are no longer in existence.

In their drive towards more efficient use of tax revenues, hospitals have directed their attention to the economies of scale that can be achieved in the operation of their plants. One of the most common of these has been the contracting out of goods and services, laundry, security, food services, plant maintenance, etc. Such arrangements usually involve a service supply company working in the hospital, providing staff, equipment, supplies and expertise to certain standards agreed to under the terms of the contract.

The contracting out of services can take a number of forms, including the full delivery of the service or just the management of the delivery. In addition, the contracting out can be to either a private not-for-profit agency, such as the central laundries where each of the hospitals holds a beneficial ownership, or, alternatively, to a private for-profit agency.

Under tab 18, which is the largest section in the book, the briefing book contains a compendium of the hospitals and their involvement with contracting out. Of the 222 hospitals, 173 are involved in one form or another of contracting out.

For purposes of the compendium, we have not included services that hospitals and most businesses would not perform on their own--for example, maintenance contracts on business machines, elevators and the like.

In a similar vein, it should be noted that the majority of supplies consumed in a hospital are purchased on the open market and, for the most part, are purchased from organizations which are operated for profit. The majority of these purchases is conducted on a public tender basis to assure price and quality competitiveness.

On page 6 is private management. While the practice of contracting out certain services has been a long-standing one, that of contracting out for the management of a hospital is relatively new and unusual in Ontario, although not so in the United States. There are two situations in Ontario: one at the Hawkesbury and District General Hospital and one at the Queensway General Hospital.

The Hawkesbury and District General Hospital continues to be a public hospital run by its board of governors. It is managed by a private firm which is responsible to the board under the terms of its contract.

With respect to Hawkesbury and District General Hospital, in 1981 it became apparent to the board of governors of the hospital of the need to improve the hospital's cash flow, to manage the hospital's spending and to improve both the clinical and administrative sides of the hospital. The hospital had a projected deficit of \$650,000 for 1982 and it had not met hospital accreditation standards for a number of years. As well, the board was faced with a need to raise one third of the capital cost of a new facility and, at that point, it had raised less than one tenth of its share.

The board realized the need to improve the professional expertise available to it in the face of these pressing problems and approached the ministry with its concerns. The board received the endorsement of the ministry to call for proposals to provide for contract management of the hospital and for the provision of capital to augment the board's fund-raising efforts.

In late 1982, following assurance that the Ministry of Health conditions were met, the board of governors awarded a contract to AMI Canada Ltd. for a 12-year period. This contract included an assurance that AMI would secure \$6 million towards the hospital's construction and renovations, with repayment to be made from the operating cost savings.

Improvements in the financial control of the hospital under AMI resulted in an operating surplus of \$400,000 in the first year. As well, clinical and administrative operations have improved to the point where the hospital has just recently been awarded a three-year accreditation. Consumer satisfaction in Hawkesbury is at a new high and the medical and hospital staffs are reported to be pleased with the improvements that have taken place.

Research on the comparative efficiency of contract management of hospitals in the United States indicates that contract management per se makes no difference in the efficiency with which hospitals are operated. With respect to Hawkesbury, it is evident that prior to AMI's involvement, the hospital was not efficiently managed and the expertise required seemed not to be available locally. The question of whether contract management would have been more effective than similarly trained and experienced hospital employees could have been, had they been available, is academic.

The benefits of contract management in this situation include the upgrading of the management of the hospital and its functions, an improved fiscal position and the availability of capital for new and needed construction. As a result of this initiative, the community served by the hospital is now receiving an acceptable standard of medical care at a reasonable cost and the debt load of the hospital has been eliminated.

The situation at the Queensway General Hospital arose out of a different set of circumstances from that of Hawkesbury. In 1981, the borough of

Etobicoke came under increasing pressure for chronic care beds. There were no designated chronic care beds within the borough, and its two hospital were experiencing a growing backlog of patients occupying acute care beds. The capital funds of the ministry were fully committed to other projects for several years into the future.

In 1981, Queensway approached the ministry with a proposal involving contract management. As a result of the ensuing discussions, the ministry approved 120 chronic care beds as an addition to the Queensway General Hospital and authorized the hospital to place an open competition for the construction and management of the facility. The call for proposals was publicly tendered by the board in 1981. A number of proposals were received and reviewed, with the result that Extendicare Ltd. was recommended by Queensway as the bidder of choice. Negotiations began and a contract was accepted by the ministry in April 1983.

The terms of the contract are that Extendicare provide two thirds of the total capital cost and the hospital provide one third, with Extendicare's portion to be repaid by the ministry at \$16 per bed-day for 19.5 years. The contract stipulates that Extendicare will manage Queensway on behalf of the board of governors. The board continues to control and to monitor quality of care. The contract stipulates the staffing required, and that is also monitored. The term of the contract between Queensway and Extendicare is 20 years.

Commencing April 1, 1982, the per diem operating cost was \$90.44. That was the base line. The resulting total cost of \$106.44 compared favourably with the average per diem of \$105.85 for similar chronic care hospitals when you recognize the \$105.85 does not include capital costs. The citizens of the borough of Etobicoke have received a new and much-needed chronic care facility for slightly more than the average cost. Current operating costs are \$124.52 per day. This amount continues to compare favourably with that of other chronic care hospitals.

There is yet another development in the evolutionary process of the funding relationship between the ministry and its hospitals. In 1982, the ministry introduced the business-oriented new development plan, BOND, which provides incentives to hospitals to operate in a businesslike manner. The key components of BOND are the consolidation of hospital revenues and expenses; the retention of net income or surpluses of income over expenses; the retention of revenue from increases in differential rates; the chronic care copayment and charges to third-party payers; and the decontrol of rates for semi-private and private accommodation.

BOND did not involve a reduction of the Ministry of Health's contribution to hospital budgets. Ministry allocations continue to flow to approved programs and services. Hospital budgets are reviewed and adjusted annually. These adjustments are kept sensitive to increases in inflation, volume of services and negotiated wage settlements. Hospitals have responded to the incentives contained in the BOND plan by vigorously controlling costs and developing revenue-generating programs.

In summary, the acute and chronic hospital sector is essentially a private not-for-profit one with a very small segment of private for-profit hospitals remaining. The private sector is extensively involved in the hospital system through the provision of goods and services that hospitals need for their operation and are either unable to supply themselves or which

can be purchased more economically and with greater efficiency on the open market. For the most part, this private sector involvement is the result of public tendering. Recent innovations, such as BOND, have allowed hospitals to benefit from savings incurred through the use of sound management practice.

Under tabs 17 and 18 there is supplementary information provided, including a list of all the hospitals, their type of ownership, bed size and current budget allocations. Tab 18 is the survey on contracted services.

14:20

The Vice-Chairman: Are there any questions at this time?

Mr. D. S. Cooke: I have a couple of things on Hawkesbury. You made the comment in the briefing that you went from a deficit position to a surplus position as a result of good management or better management. Could you outline for us the other factors that resulted in a deficit being turned into a surplus? If I remember correctly, the ministry picked up the existing deficit in one year, as it did for a number of hospitals in the province. As well, there was a significant increase in cash flow as a result of an increase in Quebec patients coming in to the hospital. I do not know the exact way it works, but do they not get to keep most of that money under the BOND program?

Mr. Reid: Yes, they do from the BOND program.

Mr. D. S. Cooke: When they increased substantially the number of Quebec patients, that increased cash flow as well. That was not necessarily a result of AMI, but a result of circumstances, as I understand it. There were a number of factors that turned it around, not only AMI and good management.

Perhaps you could outline for us what other options the hospital looked at. There was AMI and there were the Ottawa hospitals, as I remember, but the determining factor with AMI was not so much that it was a great management company, but that it had access to capital because of the fact that it is a corporation involved in the American system.

Do we know what has happened since in terms of surpluses and profits?

Mr. Reid: Have you finished the question?

Mr. D. S. Cooke: Yes.

Mr. Reid: I am trying to write down the pieces to the question.

Mr. D. S. Cooke: I want to know the whole story, not just one line.

Mr. Reid: The hospital in Hawkesbury was not efficiently managed prior to 1982-83. That is demonstrable from the deficits incurred year after year in that institution. In 1982, the Hawkesbury District General Hospital received a budget adjustment consistent with the budget adjustment given to all hospitals in Ontario at the beginning of 1982-83. That was the year we refer to as the turnaround year for hospital financing, in that we increased the hospital budgets to reflect their actual level of spending for fiscal year 1981-82, to which we then added inflation and growth on a formula basis for all hospitals.

Historically, concentrating only on Hawkesbury, no matter what the budget adjustment was there, the end result was a deficit. In 1982-83, when the budget rollover took place, they started on the same basis as they had in previous years with a break-even position and they started on the same basis as any other hospital in Ontario, but they ended fiscal year 1982-83 and subsequent years in a surplus position, which they had never done before.

The factors that contributed to how they achieved the turnaround are a series. We attribute some of it to better management. The individuals hired by AMI to manage the institution are skilled and competent administrators. Both the previous administrator and the current administrator have done an outstanding job of not only controlling expenses but also changing the complexion of that hospital.

The three-year accreditation is truly a remarkable achievement. It does not relate so much to AMI but rather to the management team, all of whom were there, save one, in 1981. To achieve a three-year accreditation on their first attempt is quite remarkable. There are teaching hospitals in this province that do not have three-year accreditations.

You are quite correct in that the Quebec revenue situation, which fluctuates, to say the least, may have contributed to a positive position in any one fiscal year. As you may or may not be aware, however, the Quebec revenue situation has turned around dramatically with the move of the Quebec government to repatriate health care to that province. The hospitals along Highway 17 are all suffering to various degrees from the vagaries of Quebec revenue; it is up and down literally on a daily basis. So while it may have contributed in the first year, it has not contributed since. In fact, Hawkesbury has lost some of that Quebec revenue base.

I cannot remember the last part of your question.

Mr. D. S. Cooke: Basically, the other question was, what has happened since the end of the first year other than getting a three-year accreditation? What has happened with cash flow and the surpluses?

Mr. Reid: The hospital has continued to operate in a surplus. I do not have the precise figures. I can get them for you if you like.

Mr. D. S. Cooke: Do you know whether they ever exceeded--what was the figure that, if they exceeded it, was 100 per cent profit for--

Mr. Reid: It was \$750,000.

Mr. D. S. Cooke: Do you know whether they ever exceeded that?

Mr. Reid: I do not believe they have, no.

Mr. D. S. Cooke: All right. If we could just get that, it would be interesting.

Queensway: How would the deal that was struck back then--and I do not remember all of its components--look now with interest rates in 1986?

Mr. Reid: That is an unfair question. Presumably, if we were to tender for that construction today, we would not pay the same interest rate. I believe the stated interest rate was 21 per cent at the time the contract was bid. The prime rate of interest at the time was 23 per cent. One would assume

that if we were bidding that contract today, we would not see 21 per cent interest on the mortgage. That is one of the reasons the mortgage was paid off at the end of 1986. It was an open mortgage. Although it had a 20-year term, it was open; so we have repaid the mortgage now.

Mr. D. S. Cooke: What is the relationship with Extendicare there now?

Mr. Reid: They are the managers of the unit. They still have a contract to manage.

Mr. D. S. Cooke: How do they get paid when there is still an additional--

Mr. Reid: They get an administration fee, but they no longer have the investment income from the mortgage.

Mr. D. S. Cooke: The additional per diem is no longer paid?

Mr. Reid: That is correct. It is no longer paid.

Mr. D. S. Cooke: How variable are the rates for semi-private and private rooms since those controls were taken off?

Mr. Reid: They are variable. Although there is a reasonable range, there is a market set, I guess, largely by the insurance companies, as it were; so the band of rates is relatively narrow. There are one or two exceptions. One hospital in southwestern Ontario has abandoned differentiating between a semi-private and a private room and simply has a preferred accommodation charge, which I believe is \$45 a day currently. That would put it over the prevailing rate for semi-private but under the prevailing rate for private.

Mr. D. S. Cooke: What has ever happened with some of the hospitals that had ideas of serving spectacular meals and so forth in some of these rooms in order to charge extra and increase their revenue? Does that still exist anywhere?

Mr. Reid: There is still some activity. There was an initial fervour for what I refer to as the bizarre, the candlelight-and-wine dinners.

The Vice-Chairman: Château Bedpan.

Mr. Reid: Hospitals set their creative juices in motion, and one hospital made up a list of 100 things it could do to raise money, including selling old operating-room gowns and--

Mr. R. F. Johnston: Used parts.

Mr. Reid: It was an exercise that I suppose was good for the soul to let them be creative, but it did not take them very long to realize that this was not all that the BOND plan was about and that the potential market for what they were doing was so limited that it was not worth the marketing effort.

Some hospitals have done reasonably well. The Ottawa Civic Hospital has changed the interior corridor of the hospital into a mini-shopping mall for patients and staff and is doing reasonably well at it. However, while I believe the candlelight-and-wine dinners are still available at the Kingston General Hospital, I do not think they are being marketed extensively.

14:30

Mr. D. S. Cooke: What is the status of the suggestion that University Hospital in London came up with to dedicate a portion of a new wing to United States or other foreign patients?

Mr. Reid: There was no formal proposal to that effect. Unfortunately, there was some musing publicly that hit the papers. The position of the minister and the ministry is quite clear. No institution will be allowed to hive off a portion dedicated exclusively to serving foreign nationals.

Interjection: There go the hopes of the Estonians.

Mr. Sargent: How closely did you check out Extendicare on its track record?

Mr. Reid: The hospital called for public tenders. We insisted on certain provisions in the contract to protect the hospital, but the decision to engage Extendicare in lieu of company X rested with the hospital.

Mr. Sargent: Extendicare's policy is to stack people at the end of the hall, pump them full of music every day and let them sit there all day like vegetables. Now they get a deal for \$106 a day for 20 years plus \$16 a day for the capital for each bed for 20 years; so we are looking at about \$24 million for beds and about double that amount for care. Are we on the same track here? These people in chronic care are paying \$16 a bed for 20 years for the capital cost.

Mr. Reid: We are not paying anything towards the capital cost. The debt has been repaid. We were paying \$16 a day, but we are no longer paying it. We have paid off the mortgage.

Mr. Sargent: You are paying \$106 a day for care?

Mr. Reid: Correct. It is \$124.52 currently.

Mr. Sargent: For \$124 they get care. What do they get from Extendicare? I think it is a production-line business, pumping people full of dope. They sit there and they do not care at all when they are in that shape.

Mr. D. S. Cooke: That is what the Tory task force said.

Mr. Sargent: I have been through these hospitals. In the morning, they line them up at the end of the hall, chair after chair, they come along with the needle, zoom, zoom, and in about four or five months a person whom you knew as being intelligent is sitting there slobbering and does not even know you. I am wondering what this is really costing us in lives. As I have heard it, Extendicare's record is not too good.

Miss Stephenson: There are two Extendicares in my riding. I will be going to the 101st birthday party of one of the residents on Friday afternoon, a very alert lady who has been there for 14 years. She is as wide awake as anybody I have ever seen. I do not know who would write the order to line them all up and fill them full of stuff by needle except the physician involved. If you have a complaint to make, you had better make it to the physician.

Mr. D. S. Cooke: What did your task force report say not too long ago?

Miss Stephenson: It said some of them were extremely good and some of them were not as good as others. That is what it said.

Mr. D. S. Cooke: But they were all being drugged up.

Mr. Wiseman: Just like members, some are good and some are not so good.

Mr. Sargent: Who wrote these reports? Who wrote this book?

Mr. Reid: We did.

Mr. Sargent: What was your mandate? To tell the story in each situation to this committee, the situation as it is today?

Mr. Reid: As I understood it, this committee was examining the role of the private sector in the health care system, and I thought it might be of benefit to members of this committee to have some--

Mr. Sargent: I am not trying to be critical. From what I have seen in the past few days, it has been a masterful presentation of what we have. But I am wondering whether we are getting the whole story in cases such as this.

I may be way off base; I do not know. But I am in these hospitals a lot, and no one in my family is ever going to go into one of those places. I would rather shoot them than put them in there.

Mr. Andrewes: That is against the law.

Mr. Sargent: I know, but what they are doing is against the law. They are getting away with what they are doing now. It is unbelievable.

The Vice-Chairman: Do you have a question, Mr. Sargent?

Mr. Sargent: I had better keep quiet. That is all for now.

Mr. Reycraft: Have other hospitals sought the ministry's endorsement of contract management proposals or agreements, such as were approved for Hawkesbury?

Mr. Reid: There was one other, in Cochrane.

Mr. Reycraft: How long ago was that?

Mr. Reid: In the late 1970s.

Mr. Reycraft: So that was previous to the Hawkesbury situation?

Mr. Reid: Yes.

Mr. Reycraft: And no other hospitals in the province have sought approval of that since?

Mr. Reid: No other hospital, to the best of my knowledge, has approached the ministry with a formal proposal. I know that hospitals have looked at both AMI Canada Ltd. and the Hospital Corp. of Canada Ltd. as potential managers for either all or part of their institutions, but none of them has approached the ministry to seek approval.

Mr. Reycraft: Given the apparent success of the Hawkesbury project and the problem that a number of hospitals are having in balancing their budgets, I find that somewhat surprising. Is there an explanation?

Mr. Reid: I believe the circumstances that led to the introduction of contract management at Hawkesbury were unique.

I do not know how familiar you are with Hawkesbury, but there were three hospitals there at one time. There were two sister hospitals, each run by a different order of nuns, and a private hospital, the Smith Clinic. They were all old, with very poor physical plant.

If there was ever a single community in Ontario that begged for redevelopment into one hospital, it was Hawkesbury. When I joined the Ministry of Health in 1969, the number one capital project of the Ministry of Health--we were then a commission--was the rebuilding of the hospital in Hawkesbury. That was in 1969.

The community is quite poor. It has suffered some economic setbacks over the years, and the hospital was very badly managed. If you put all those things together, you end up with the circumstances that led them to have a tender call for somebody to come in, manage the existing institution and help build a new one.

The community share for that project was approximately \$6 million, and that money was simply not available. If I recall correctly, a Canadian International Paper plant in Hawkesbury was closing or had closed at that approximate time. Unemployment was exceedingly high. The possibility of raising that much money locally was nil.

They entered into a contract with an organization that came in and guaranteed that it would underwrite whatever the community could not put up. Only one other bidder for the project was close, and that was Ottawa General Hospital. Ottawa General failed in its bid because it would not guarantee to pick up the community share.

Going back, the factors that led to the situation in Hawkesbury are unique. Those factors do not exist or do not appear to exist in other areas.

14:40

Mr. Reycraft: I do not doubt your statement, but certainly a number of hospitals are experiencing chronic budget problems and are looking for additional funding. Is it not possible that the solution to the dilemma facing those hospital boards might be some form of contract management?

Mr. Reid: The solution could well be a change in management, not necessarily contract management.

Mr. D. S. Cooke: That is assuming all those hospitals have a deficit as a result of bad management. The best management in the world cannot turn some hospitals into a balance or surplus position if they are underfunded, unless they contract out everything and pay one minimum wage.

Mr. Reid: I do not subscribe to the notion that hospitals are underfunded.

Mr. Andrewes: I guess there is a certain comfort that hospital boards feel by having their own administrations. There is a certain pride too,

is there not? The hospital board would be hard pressed before it would go to a management firm and say, "You take over the management of this hospital." I think they would feel they had failed the people they have committed themselves to serve.

Mr. Reid: To get to that point, the board would have to be saying to itself, "We cannot find an alternative." Going back to Hawkesbury, there was no alternative in the minds of the members of the board. They could not recruit anybody from Ottawa, which I guess would be the closest, or Montreal to come to Hawkesbury to do it; so they ultimately went to an organization which recruited on their behalf. The administrator who is currently there, Michel Lalonde, would not be there working for the Hawkesbury board; he is there only because of AMI.

Miss Stephenson: Will you confirm or deny the rumour that during the late discomfiture at the Toronto East General and Orthopaedic Hospital, a suggestion was made in the interim period that something such as AMI or a management company might be required to keep that institution going in the direction the commissioner who was appointed tried to establish?

Mr. Reid: Are you referring to when East General was put under supervision?

Miss Stephenson: Yes.

Mr. Reid: To the best of my knowledge, the notion of contract management was never broached, certainly not by the ministry.

Miss Stephenson: A couple of board members suggested this was--

Mr. Reid: It was never broached by the ministry.

Miss Stephenson: The ministry was never approached with the idea?

Mr. Reid: Correct.

Mr. Andrewes: Mr. Reid, the appendix in the back is a very extensive listing of the services that are contracted out. For the most part, they are food services, laundry, security and, to some degree, maintenance. I noticed one or two in particular. I think Meaford General Hospital contracted out certain services for equipment, and I think it was ultrasound. I would assume that a hospital of that size would perhaps lack certain specialized equipment. Is that the sort of thing that is at the discretion of the hospital board, or is it something the ministry encourages one way or the other?

Mr. Reid: We actively encourage the contracting out of only two types of services. One is the joining of central laundries. A number of central laundries across the province have been built over the years, and we encourage hospitals in that region to participate in the central laundry because it creates an economy of scale. In the Ottawa Valley, we encourage hospitals to join the Ottawa commissariat, which is the same principle, only it is the supply of food. The balance of contracting out is a decision that is taken by the board. We normally do not know about it until it is done.

Mr. Andrewes: Are those specialized services readily available on a contracting-out basis or are they very scarce?

Mr. Reid: Which special ones are you referring to?

Mr. Andrewes: Ultrasound, for instance.

Mr. Reid: I do not know.

The Vice-Chairman: Mr. Reid, would you be able to elaborate further on the economic aspect of the business-oriented new development program. What kind of savings has it generated? What is the economic benefit-cost outlook of such a program? What kind of motivation have you seen? I know you talked about the qualitative aspect, but how about the quantitative aspect?

Mr. Reid: We have looked at the system in total. What we have seen from the last three years is that increasingly hospitals are aware of improving the productivity of their departments. We have some macro-indicators that will demonstrate that the hospital system has improved productivity by an amount equal to \$50 million over the four years since the BOND program was introduced. It is difficult to identify what happened to the money, but we are sufficiently confident to say that it is in the system. It has been redirected within the system.

Essentially, what we have done is create an incentive for the hospitals to manage and ultimately make their own decisions on what to do with the savings. If they can save money through contracting out or through improving the manner in which they do business, they can use that money to supplement the services they are provided or start a new program.

The Vice-Chairman: The outlook for the BOND program is still very promising.

Mr. Reid: We are still encouraged by the results. There is no question that further improvements in the reimbursement system and formulae that we use will always take place. While we do not subscribe to the notion that the system is underfunded, we acknowledge that from time to time there are situations that arise that are not fully compensated in the reimbursement system, and we continue to fine-tune the system.

The Vice-Chairman: Would you say that today in 1986 the gains brought about by the BOND program are as strong, stronger or weaker than when the program was first started?

Mr. Reid: I think the potential for further gains is relatively limited, at least in the traditional sense. There may be more to gain in the long run with some substantial organizational changes. The movement towards association or merging appears to be much stronger. The incentives and the opportunities for a hospital to realign spending programs as a result are much greater than simply looking within its own shop and making the laboratory as efficient as possible. I think the opportunities created by the pooling of interests of Toronto General and Toronto Western are quite substantial.

The Vice-Chairman: Would you say that the privatization for profit of services given to hospitals in 1986 and in the near future will be a more and more interesting aspect of hospital management?

Mr. Reid: I am sorry. Do you mean the privatization of management?

The Vice-Chairman: Is there still a trend to go more and more towards the privatization of services that were sometimes done in-house in hospitals? Does the outlook seem to indicate that the economics might invite this on a greater scale?

Mr. Reid: There will be more privatization over the next decade as hospitals move to eliminate functions that someone else can do for them at a better price or quality. I do not see any major inroads.

One of the purposes of a compendium was to show how widespread the pooling of interest now is. Of the 222 hospitals, 173 now involve one form of contracting or another. Of the 48 hospitals that do not have any contracting out, half of them are in the north and never will contract out because, if you look at the map, there is nothing in the immediate vicinity. Of the 24 remaining hospitals, some movement is probable in that area.

The most likely thing to occur over the next decade is not the privatization of laundry or dietary but rather the pooling of interest in hospitals. We will see more and more free associations. They may not be mergers in the classic Toronto General-Toronto Western sense, but a pooling of interest or a formal association.

Mr. R. F. Johnston: I specialize in free association myself.

It is not a question at all; it is just to compliment you on the compilation of information. It is the first time I have ever seen anything like the contracting-out information and it is quite useful to have. Thank you very much.

Mr. Reid: You are welcome.

Mr. Baetz: My question relates to the cost of administration, running a hospital as compared to the other costs.

The reason I ask this is that a few Sunday afternoons ago over a few beers in a social with some of the outstanding doctors of the Ottawa Civic Hospital cardiac unit, we got to talking about the tremendous cost of keeping somebody in the hospital or an operation. I do not know whether it was the beer or not--I do not think so because we did not drink that much--but I was amazed when the doctors gave me a breakdown of what it really costs, at the amount the surgeon gets.

Let us assume an operation, a transplant or whatever, costs \$4,000. When you break down that cost, I was astounded at what the experts were getting--the surgeons, the nurses and the attendants--as compared to what the front office was getting, the administration or PR or whatever. This was not an attack on the administrator, I want to make that clear.

Does this concern you at all? Has the ministry really looked at the administrative costs as compared to the other costs? Perhaps implicit in this question is also the fact that the board seems to be satisfied with their administrators or directors, but maybe we are paying a pretty high price for them. Maybe that is why we are getting a very expensive administration but also very good administration.

Mr. Reid: Although the two do not necessarily go hand in hand.

Miss Stephenson: Absolutely.

Mr. Baetz: Not necessarily at all.

Mr. Reid: Certainly some of our more expensive administrators are not some of our best.

Miss Stephenson: We should probably publish the list of rates of emolument for some hospital administrators. In some instances it equals that of directors of education.

Mr. Baetz: What is the view of the ministry? Obviously, you people have to be looking at these things. Are you concerned about this? Do you think maybe there is room for correction here? After all, if I am in for a heart transplant, if I had my druthers, I would sooner be sure to pay the surgeon a little more than the fellow who does the PR brochures.

Mr. Reid: We review all of the costs of hospitals and continue to encourage hospitals to improve on their rate of spending.

Mr. Baetz: That is an overly cautious comment. You must have more views on this than that.

Miss Stephenson: I submit there is a degree of benevolence within the ministry because the ministry regards the hospital boards as locally elected groups of people who take on the responsibility of ensuring that the institution is administered appropriately. Just as provincial governments are loath frequently and usually to interfere directly into the election of municipal governments or school boards, the same kind of relationship occurs between the Ministry of Health or the government and a local hospital board.

There is or has been from time to time a role of activism assumed by the ministry when such institutions as the Toronto East General and a couple of others, which I could name and probably will not because they are related to teaching institutions, have had either direct invasion, one might say, of their responsibilities or vigorous consultation of a very persuasive kind that assisted somewhat in the redirection of the management of the institutions.

The one thing that continues to concern many people, and I find it a little bit troublesome from time to time, is that in many instances hospital boards are somewhat self-perpetuating and in many instances do not necessarily represent the entire range of community for which that hospital is said to be responsible.

I think there needs to be some kind of mechanism, an amendment to the Public Hospitals Act, which would ensure there is a little greater democracy in the election of hospital boards than there has been traditionally. I say that knowing full well that the vast majority of citizens in a community will not bother to shake their boots to get out to elect anybody at any meeting for anything. They do not do it for school boards and they rarely do it for municipal councils. None the less, it would be nice to have the feeling of comfort that there was an opportunity for greater democracy within the election of hospital boards. I think if that were to happen, we might, though this might be pie-in-the-sky, have a more critical assessment of the administration of a number of the institutions. We might and one would hope that we would.

The Vice-Chairman: Would you like to react to that, Mr. Reid?

Mr. Reid: No.

Miss Stephenson: He would not dare. I can say it. The minister--

Mr. Chairman: As a good chairman, I offered you the opportunity.

Mr. Reid: I just was not aware that there are degrees of democracy.

Mr. Sargent: To my knowledge, there has never been in my 25 years around this place such an animal as this committee to take an overall look at health and what powers we have. Mr. Baetz was saying we know what a guy in a plant makes, so much an hour. I have no idea what a surgeon would charge for a brain operation. Naturally, you want the best working on you, but what is the rate structure of these guys?

Miss Stephenson: Look it up. It is all published in public information. The OHIP schedule of fees and the OMA schedule of fees are both public documents. I will bring you a copy.

Mr. Sargent: Maybe we will find they are too high. Let us table that then until tomorrow. If Miss Stephenson will bring it tomorrow, we can have a look at what these guys are making. They might be making more than a member of Parliament; you never know.

Mr. Baetz: We all know what the OHIP fees are for various operations, for surgeons and for various practitioners, etc., but is the same kind of information available and widely publicized concerning the salaries of the front office people: the administrator of the hospital, the director of public relations, the government relations man and on and on? Are those salaries publicized in any ministry documents, even recognizing that you people do not decide what they are, but just as a matter of public information?

Mr. Reid: No. That information is not published in any form.

Miss Stephenson: Is it ever made broadly available to the ministry now?

Mr. Reid: We have access to much but not all of it.

Miss Stephenson: How many hospital administrators are this year being paid more than \$125,000?

Mr. Reid: A number.

Mr. Baetz: Quite a number.

15:00

Mr. Sargent: One thing we should keep in mind is to open the books to let us see what is involved at these top levels. We hear of lawyers making \$1,000 a day. Even in this building lawyers are making \$1,000 per day in committees. Lawyers in Toronto are charging \$5,000 per day. What does a surgeon get for a heart operation or a brain operation? Does he get \$5,000 or is it so much per hour? I do not know. Let us have all that stuff.

Mr. Reid: That information is available. The OHIP schedule of benefits is a public document.

Mr. Sargent: Let us table it before this committee.

Finally, I think that says the makeup of hospital boards is not of the people. It is more or less a class--

Miss Stephenson: Not all of them.

Mr. Sargent: A lot of them, though. In the towns, it is the in thing to be on the hospital board with a certain clique. It should be spread across the citizenry at large to have a say in what goes on at that hospital. It belongs to the people.

Mr. Reid: That is a difficult proposition.

Mr. Sargent: The building is local.

Mr. Reid: I live in a condominium corporation in which there are 150 tenants. One would assume that since we all live there, we would all like to share in the administration and serve on the board. I can assure you that 85 per cent of the people living in my project have no interest in serving on the board.

Mr. Sargent: Do you not agree the option should be there?

Mr. Reid: However, it falls to those who are willing. Many hospitals have found themselves in that sort of pickle. If there was one thing wrong at the Toronto East General and Orthopaedic Hospital to which you could point, it was the self-perpetuating board. No one else wanted to serve; so people kept going on and on.

Mr. D. S. Cooke: It is not quite that way.

Mr. Reid: It is not always that way, but that is one of the factors.

Miss Stephenson: Under the circumstances, it sure was.

Mr. D. S. Cooke: I have been trying for a year now to find out how to belong to one hospital, so that I could tell some constituents how to go to an annual meeting.

Miss Stephenson: All you do is to pay your donation to the hospital.

Mr. D. S. Cooke: It is not always that way.

Miss Stephenson: Do they not allow you to do that?

Mr. Reid: There are some boards that really are closed.

Mr. Baetz: To get back to these administrative costs, has the ministry ever tried to do a systematic comparison? I know that is always a fuzzy-ended thing, what is administration and what is not, but I think you could get a pretty good handle on comparing the administrative costs of hospitals in Ontario with some of the privately run hospitals or even others in the United States or elsewhere. Has the ministry ever looked at that, or are you saying administration costs are a local prerogative?

Mr. Reid: We compare hospital administration costs inside Ontario with similar-sized hospitals in Ontario. We stack hospitals up against their peers, if you like. We compare Ontario hospitals against all the hospitals in Canada. The majority of hospitals subscribe to the QIS system, which is what we have. It is a quarterly information system for all the hospitals in Canada. In addition, Ontario participates with the western provinces in a special comparison of selected Ontario hospitals against peers in western Canada.

My division has not compared Ontario's administrative costs against those in the US. That would be an exceedingly difficult comparison. The

definitions are different. To take all that data, pull it all apart and try to get some apple-to-apple comparison would be too time-consuming.

Mr. Baetz: How do we compare with other Canadian hospitals?

Mr. Reid: We compare reasonably consistently.

Mr. Baetz: I know it is difficult to compare apples with apples, but it might be a useful exercise. This is a very important part of the whole hospital costs figure.

Mr. Reid: I can give you a very general comparison. Our hospitals would compare exceedingly favourably with American hospitals. The cost of administering a Canadian hospital is much less than it is in the United States. I have toured US hospitals. I have toured the accounting department of the Johns Hopkins hospital and others, and their administrative staffing is immense in comparison to ours.

Miss Stephenson: There is a multiplicity of payment mechanisms that have to be taken into account; we have only one.

Mr. Reid: That is right. The accounts receivable department at Johns Hopkins is bigger than the accounting department of the Ministry of Health. They have hundreds of people.

Mr. R. F. Johnston: We cannot let that go.

The Vice-Chairman: Why?

Mr. R. F. Johnston: Let us catch up.

Mr. Reid: No. We have no interest in competing.

Interjection: That is what government control does. It makes it very inefficient.

Mr. Andrewes: May I embark on another vindictive flight of fancy? Randy, what criteria do you use to judge whether a hospital under the BOND program has accumulated sufficient surpluses for you to begin to recapture some of those surpluses?

Mr. Reid: We do not recapture the surpluses.

Mr. Andrewes: At some point, some hospitals will consistently have surpluses, I would assume--

Mr. Reid: Yes.

Mr. Andrewes: --and will generate substantial amounts of reserves as a result of those surpluses.

Mr. Reid: You are assuming that all the surpluses end up as money in the bank. Not all surpluses end up as cash in hand. Every hospital in the province should have a positive bottom line. Its current revenue should exceed current expenses by a proportion. The right proportion will be determined by each hospital.

On a system-wide basis, we use two per cent as a rule of thumb. If the

current income exceeds current expenses so as to produce a two per cent net income, the system is healthy. That is what it has produced historically; that is what it should continue to produce. That surplus is then used to reinvest in the physical plant, for both equipment and construction. In some cases it is indeed put into the bank for a rainy day. It may not be used in the year it is generated, but it is used.

Mr. Andrewes: I understand that. Have you ever run into a situation where you felt as an administrator in the ministry that a hospital's surpluses, its moneys in the bank and its reserves, were not being reinvested in the plant and that you needed to give it some direction that it had to be done?

Mr. Reid: There are hospitals in the province that, in my opinion, have money in the bank that they do not need for the foreseeable future. We have not directed them in any case to spend that money. They continue to accumulate those surpluses, and we have a number of hospitals that, when the time comes for them to rebuild, will be in a position to rebuild. The Hospital for Sick Children is a good example of a hospital that accumulated money for a long time, and continues to accumulate money, but is about to invest it in a massive rebuilding program.

Mr. Reycraft: How many hospitals in the province meet the two per cent criterion that you mentioned?

Mr. Reid: The system in total meets the two per cent criterion. I do not know specifically how many are at two per cent or how many are above or below, but the system meets the two per cent criterion.

Mr. Reycraft: Does the ministry have the information it would need to answer that question?

Mr. Reid: We would have it for up to fiscal year 1984-85 in our published statistics. I would not have it yet for 1985-86.

Mr. Reycraft: Would it be possible for us to receive the information for 1984-85?

Mr. Reid: Sure.

Mr. D. S. Cooke: What are you going to do--move some money around so that everyone has two per cent?

Mr. Reycraft: I just want to know how many of them meet it and how many do not.

15:10

Miss Stephenson: If you see that some of them are chronically behind, surely you begin to ask questions about administration and about the way in which the hospital is organized and run.

Mr. Reycraft: That takes me back to my first question some time ago.

Miss Stephenson: I want to ask whether you have yet another means of ensuring that if reserve is accumulated as a result of BOND and if the hospitals intend to use it for equipment--as I understand it, there has never been in the budgetary process any mechanism otherwise for hospitals to build up a reserve to replace worn-out equipment.

Mr. Reid: The budget allocation allows provision for depreciation based on historical costs.

Miss Stephenson: It is relatively small and does not necessarily meet the increased cost of replacement.

Mr. Reid: That is correct.

Miss Stephenson: There has been that kind of circumstance for at least 25 years that I am aware of.

Mr. Reid: That is correct.

Miss Stephenson: It might be even longer. I gather this is something that is shared with most hospital institutions across Canada. It is not something that is unique in this province. If a hospital does accumulate some funds as a result of BOND, frequently the route it will pursue is the purchase of a new piece of equipment for which there will be an ongoing day-to-day operating cost. To achieve that cost there is--not supplication--some kind of approach to the ministry to adjust the budget base to allow that to occur.

Mr. Reid: That is not necessarily true.

Miss Stephenson: If they were going to buy a lithotripter, for example--I will not mention the word; if they were going to--

Mr. Reid: If they were to, yes, we would stop them. The hospital has a current surplus, which means it has the capacity within its current resources to provide some or all of the operating costs of the lithotripter, and if it has accumulated enough money to purchase it, the deal is done--except that a regulation precludes the purchase of a lithotripter.

Miss Stephenson: That is exactly right at this stage of the game.

One of the questions you asked a while ago was whether it was very common practice for the contracting out of certain kinds of slightly exotic, but now not really, services. I have found that it is not one of the things that is encouraged by the Ministry of Health because Toronto might have been blessed with that machine if the ministry had decided that a couple of the hospitals--in fact, four of the hospitals--could contract out the service because there was a private group that was willing to buy the machine and have it here. Will Wellesley get its machine in 1987, 1988 or 1989?

Mr. Reid: It will be here in November.

Miss Stephenson: Running in 1987.

Mr. Andrewes: What is it?

Mr. Reid: A lithotripter, a stonecrusher.

Miss Stephenson: It is a stonecrusher.

All I was suggesting was that they might seriously consider changing the policy to allow for that kind of contracting out when it is so difficult to find the capital money and the capacity to purchase that kind of equipment.

Mr. Reid: The ministry is always prepared to examine innovative solutions to health care problems.

Miss Stephenson: Yes, Mr. Reid, we examine them.

Mr. Reid: We examine them.

Miss Stephenson: We examine them and examine them and examine them.

Mr. Reid: We try them and find some of them wanting.

Mr. Sargent: In this field there have been a lot of shaggy operators over the years. We are going to be talking about other things, and in case we do not come this way again, I would like to put on record that every institution engaged in chronic care--hospital wings, hospital annexes, senior citizen retirement centres and all places where barbiturates and drugs are injected, dispersed or dispensed--should make a monthly report to a separate monitoring government agency. This agency shall investigate not less than four times a year and issue a report of excessive or above-average practices. In such cases it will be judged a serious offence. Their licences will be placed in jeopardy, along with heavy fines.

Somewhere along the line we have to put a cap on this. I watch this stuff too much and I think it is time we did something concrete. Perhaps now is not the time, but if that is on the tape now we can come back to it.

The Acting Chairman (Mr. Reyecraft): Fair enough.

Miss Stephenson: Are you going to go into senior citizen's residences as well?

Mr. Sargent: I want to ask your advice on that.

Miss Stephenson: This has been going on in North York for the past year. A clinic is held in each residence on an irregular basis. It has been found that most of the senior citizens living independently in the residence have bags full of more than 45 prescription drugs, some of which they are taking, some of which they are not. It is not just the operators of chronic care wings, extended care wings, nursing homes or anything else. In fact, the practice of prescribing drugs for senior citizens has to be examined critically and modified dramatically.

Mr. Sargent: You would not let these old people carry guns in their wallets, would you? You do with those pills.

Miss Stephenson: Dear heart, in many instances all they do is eat toast, drink tea and take whatever new prescription--

Mr. Sargent: I am not that old yet; I do not know that.

Miss Stephenson: Lots of them do because they do not have any appetite to eat anything else.

Mr. Sargent: Okay.

Miss Stephenson: There is a problem but it is not one that can be addressed simply by that kind of inspection.

Mr. Sargent: That is what these guys get paid for. Let them have something to do.

Miss Stephenson: They also get paid for being imaginative about providing community programs to ensure that people are not in institutions. Perhaps that is one of the areas we should be looking at enthusiastically and spending money on rather than spending money on inspections which may not solve any problems.

The Acting Chairman: Are there any further questions on the matter of hospitals?

Mr. R. F. Johnston: You are doing a great job.

Mr. Andrewes: Next?

The Acting Chairman: Nursing homes.

Mr. Corder: The nursing home system is under tab 15 in the binder. I am going to use notes, as I did this morning. I will not read you the whole presentation.

Nursing homes form a major component of the Ontario health care system. They began as private institutions providing a level of care that was less intensive than hospital care but more than the care provided by families in the home. This general description is still appropriate.

During their early development, nursing homes existed without provincial regulation or consistent standards. Payment for care was the responsibility of the individual resident through family resources, private insurance or welfare payments.

During the early 1960s there were two significant developments which impacted on the future of the nursing home sector. In 1964 the Ontario government introduced the homes for special care program. People were discharged from provincial psychiatric hospitals and facilities for the mentally retarded to residence in the community. Nursing homes were used extensively to implement this program. Concerns were expressed about the ability of these homes to provide the appropriate and necessary care.

During this same period, the Ontario Welfare Council undertook a study of Ontario nursing homes which indicated wide disparities in the type and quality of care provided. In 1966 the provincial government responded to these concerns by passing the Nursing Homes Act, which set standards governing care and accommodation in nursing homes, as well as requiring licensing by the department of health.

15:20

Extended care is the insured health service that is provided in nursing homes and in homes for the aged. During the 1960s, the government began to recognize that individuals and families were not always able to afford the costs of long-term care in nursing homes. Some individuals were receiving assistance through local welfare systems, but in 1972 the Ministry of Health recognized extended care as an insured health service and began to provide funding for it. In 1977, the federal government began to contribute towards the costs of extended care services.

The Nursing Homes Act, 1972, defines the parameters under which the nursing home system operates. It describes the process by which nursing homes are licensed, the conditions required to maintain a licence, the process of

inspection and licence renewal, the procedures of the Nursing Homes Review Board, provisions for the appointment and definition of power of inspectors, penalties for failure to comply with the act and its regulations and definitions pertaining to the regulatory powers of the Lieutenant Governor in Council.

The nursing homes branch of the Ministry of Health is responsible for the inspection of all licensed nursing homes in the province to ensure they are in compliance with the act and regulations. Each home is inspected on an annual basis prior to the renewal of the licence. Violations of the act are cited and recommendations to bring the home into compliance are made. The owner is responsible for advising the ministry of plans to achieve compliance within a specified time period.

There are several other types of inspections carried out. These include follow-up inspections, inspections prior to the sale of a home, complaint inspections and incident report inspections. Inspections are carried out in four major areas: nursing, environmental health, fire safety and nutritional care. Over the 15 months from November 1984 to January 1986, there were 4,519 inspections carried out by the branch. This represents an average of 13.7 inspections per home.

Compliance with the act and regulations is maintained in three basic ways: recommendations of the inspectors, prosecution and, in the most severe cases, revocation of the licence. The inspection and compliance system for nursing homes was recently reviewed by the firm of Woods Gordon, management consultants. The consultants' report is currently being analysed by the Ministry of Health and will be released in mid-September.

In 1984, prosecution action was initiated against 20 homes, and in 1985 against eight homes. As of June 30, 1986, action has been initiated against nine homes. During 1982 and 1983, there was a total of 33 letters of intent to revoke nursing home licences issued. Of these, 19 homes took the necessary action to correct the identified areas of noncompliance; 12 homes closed; one home was sold; and in one case the Nursing Homes Review Board deferred revocation proceedings pending completion of a replacement facility. At present, there is one letter of intent to revoke a licence awaiting hearing before the review board.

Extended care is defined as a requirement of a minimum of 1.5 hours of nursing and personal care per day. As well as nursing care, it includes drugs and regular domiciliary services and activities of daily living. The need for extended care is a medical determination, and the benefit is granted only after documentation of information provided by the resident's physician.

The primary group served by nursing homes is the elderly. As of July 31, 1986, there were 29,268 residents in the nursing homes under the extended care program. Persons over the age of 65 years occupied 26,193 beds, or 89 per cent of the total occupied beds. More significant is that 17,934 people were over the age of 80 years. This represents about 61 per cent of the total occupied beds in nursing homes.

Mr. Sargent: That is amazing, is it not?

Mr. Corder: That is correct.

The operating costs of a nursing home are financed through per diem amounts negotiated between the ministry and the industry. The per diem rate is

financed by both the province and the resident. The resident's portion is based on income received from federal old age programs. The maximum resident payment leaves the resident a monthly amount for incidental expenses. This comfort allowance is currently set at \$112 per month for those over the age of 65 years. Residents also pay the additional costs associated with semi-private and private accommodation.

In 1972, the per diem rate was \$12.50, with the province paying \$9 and the resident paying \$3.50. These rates have steadily increased over the years until at August 1, 1986, the per diem rate is \$48.90, with the government portion set at \$28.88 and the resident's portion at \$20.02.

The total ministry transfer payment for extended care has also increased. The figures are from \$30,749,000 in fiscal 1972-73 to more than \$265 million in 1985-86.

Capital construction costs are not supported by the provincial government through grants. Capital financing for nursing homes must therefore be supplied by the owner, be that a profit or nonprofit operator. Repayment of capital is financed through the operating budget.

Since the extended care program commenced in 1972, the number of nursing homes has decreased by 31 per cent, while the number of beds has increased by 34 per cent. As of July 31, 1986, there were 332 nursing homes and 29,884 licensed beds. More than 80 per cent of the nursing homes are less than 120 beds in size. The smallest home is 16 beds and the largest home is 326 beds.

Nursing homes are currently operated by a variety of profit and not-for-profit organizations in several legal forms. Of the current 332 licensed homes, 30 are operated by nonprofit organizations. This represents nine per cent of the homes and approximately six per cent of the total number of beds.

The remaining 302 homes, with 28,103 beds, are operated on a profit basis. This represents 91 per cent of all the nursing homes and approximately 94 per cent of the beds. Of the 30 nonprofit homes, three are owned by municipalities, two by Indian bands, eight by hospitals and 17 by charitable, religious and community groups. Two of the nonprofit homes have contracted with private nursing home operators to provide the management of the homes.

Private nursing homes may be either proprietorships and partnerships or corporations. Of the 302 profit homes, 37 are not corporations and 265 are corporations. For purposes of illustration only, we have defined a nursing home chain as a corporation which operates three or more nursing homes. Within this definition, recognizing its limitations, there are currently 26 chains operating 155 nursing homes with 18,022 beds. This represents 51 per cent of all private nursing homes and 64 per cent of the total number of beds.

In recent years, the nursing home industry has undertaken a process of accreditation review under the auspices of the Canadian Council on Hospital Accreditation. Inspections are carried out on a one-year, two-year or three-year cycle. Homes which are operating within the standards set by the council gain accreditation status.

In an effort to encourage homes to participate in this quality care program and to defray the costs of the process, the province pays to each accredited home an annual grant, which is based on 26 cents for each day of care provided by the home. More than 70 per cent of licensed nursing homes are accredited.

New nursing home beds are licensed on the basis of a public tender process. The ministry releases a request for proposals and any person or group is entitled to apply for a licence to operate extended care beds. Written proposals are reviewed and interviews carried out prior to the granting of a licence. Recent policy changes have resulted in a stated preference for nonprofit applicants. As well as the public tender process, the minister may award up to 10 beds directly to a specific nursing home, based on need. Copies of general information on senior services and facilities, a list of licensed nursing homes and federal guidelines on long-term care, and information on the bed-tendering process have been filed in the appendices and the bibliography to the nursing home section. I would be pleased to answer any questions.

15:30

The Acting Chairman: Any questions?

Mr. Corder: I believe the bibliography is on the last page of that section.

Mr. Andrewes: You have given us the bibliography, but you have not given us the reference material.

Mr. R. F. Johnston: My question actually goes back to this morning rather than this afternoon. It strikes me now, just in comparing our homes for special care knowledge and our nursing home knowledge, that there is a fair amount of difference, partly because nursing homes have been a political issue. What sort of licensing information do we have about homes for special care in comparison with the information we can get about nursing homes in terms of who are the operators, that whole listing of who owns what and what they have to go through to get a licence?

Mr. Corder: I can provide you with that information, the whole tendering process. I can also get you a list of all the nursing homes in the province.

Mr. R. F. Johnston: But for the homes for special care?

Mr. Corder: I can indicate which nursing homes in the province also have a homes for special care licence. That information is available.

Mr. R. F. Johnston: Are there homes for special care which are not nursing homes?

Mr. Corder: Homes for special care which provide extended care must be nursing homes. There are homes called residential, which are like boarding homes, which I spoke about this morning, that really are not nursing homes. They have an HSC licence only.

Mr. R. F. Johnston: Is it possible to get that kind of information about them?

Mr. Corder: Yes.

Mr. R. F. Johnston: That would be interesting, if you can. I have never seen that kind of break-out.

Mr. Corder: Lists of everything?

Mr. R. F. Johnston: Yes.

Miss Stephenson: May I just ask whether the statistical information you have given us here about the residents and the numbers of beds apply to nursing homes on an extended care basis, including homes for special care patients, or are they extended care patients in the usual sense of the word?

Mr. Corder: These include all patients who are eligible for extended care, including homes for special care.

Miss Stephenson: How many of the 29,000 and some-odd patients in beds in nursing homes at present would be classified under the homes for special care circumstance?

Mr. Corder: About 4,000 or 5,000.

Miss Stephenson: We have about 5,000 in total--

Mr. Corder: I believe 6,000 in total.

Miss Stephenson: There were 5,583 patients in homes for special care, as I recall from this morning. What you are saying is all those are in nursing home beds?

Mr. Corder: All those who would be eligible for extended care benefits. Those who are in the residential would not be counted. I am sorry it is confusing.

Miss Stephenson: I need to have that kind of classification and breakdown.

Interjection: It would include some mental patients.

Miss Stephenson: Obviously it does. Extended care covers it.

Mr. Corder: Some.

Miss Stephenson: Some? Then I need the developmentally handicapped.

Mr. Corder: In the homes for special care program, in 211 nursing homes, we have 3,548 HSC residents. In the residential component--that is, the boarding home component--there are 2,030. In that total number of extended care people who have been identified at the presentation this afternoon--

Miss Stephenson: There are 3,000.

Mr. Corder: We have 3,548 who are HSC. That is across the system.

Miss Stephenson: Do we have a breakdown of those as well? Do we know how many of those are developmentally handicapped?

Mr. Corder: Yes.

Miss Stephenson: And how many would be classified as mentally ill?

Mr. Corder: Yes. In nursing homes, 1,726 are developmentally handicapped, and in the boarding home component, 423 are developmentally handicapped.

Miss Stephenson: That means 2,000 and some are classified as mentally ill, long term.

Mr. R. F. Johnston: The second question I am interested in knowing a little bit more about is the chains. You say 26 chains take up 51 per cent of the nursing homes and 64 per cent of the beds. I presume some of those are small outfits with three or four homes, but some of them are the biggies. Can you give us an idea of the corporate concentration?

Mr. Corder: All right. On page 8 of the presentation, there is one minor step towards answering your question. You probably want a more definitive breakdown than that.

Mr. R. F. Johnston: Yes. I am interested in the 26 chains within that. Of those 26 you have Extencicare, plus a few of the others that are big multinationals. I am interested in knowing their percentage of that number of beds, so we can get some idea of the top five or six. Presumably about six chains would be fairly large.

Miss Stephenson: Could we have a definition of the Canadian multinationals as compared to the multinationals of other countries?

Mr. Andrewes: Canadian multinationals?

Miss Stephenson: We do have some multinational firms now that were developed in Canada.

Mr. R. F. Johnston: A rose by any other name.

Mr. Sargent: Has anyone ever heard of a nursing home going broke?

Miss Stephenson: Yes.

Mr. Sargent: Have you? It says here on page 6 that in 1972 it cost \$12.50 per day per inmate.

Mr. Andrewes: Resident.

Mr. Sargent: Yes, resident. In 14 years there was a 400 per cent increase to \$50 per day, which is \$1,500 a month per person in a home. No damned wonder hotel rates have gone up to \$75 or \$100 a day downtown when it costs \$50 a day in a nursing home.

Miss Stephenson: Which came first? The increase in hotel rates or the increase in nursing homes?

Mr. Sargent: If I had a hotel, I would sure as hell--

Miss Stephenson: Turn it into a nursing home.

Mr. Sargent: --charge more than \$50 a day because you could get a nursing home for that. The point is--what was my point?

The Acting Chairman: The point is to ask questions.

Miss Stephenson: It would be interesting, Eddie, to have a comparison of the rate of increase in acute hospital care costs between 1972 and 1986 and the rate of increase in nursing homes, to see whether the

increases have been about the same. I am willing to wager they have not.

Mr. Sargent: Here is one. The largest nursing home has 326 rooms that can take in half a million dollars a month of our money. That is big business. I will get on track in a minute. I am trying to think of something.

The Acting Chairman: Are there other questions for Mr. Corder?

Mr. Andrewes: I will be the devil's advocate to some degree, Mr. Corder. Is the per diem for homes for the aged the same?

Mr. Corder: I do not believe so.

Mr. Andrewes: Is the level of care the same?

Mr. Corder: Certainly, the extended care portion of the homes for the aged would give the same kind of care as is provided in a nursing home. Many of the homes for the aged have the residential component which is somewhat different.

Mr. Andrewes: I appreciate that, but in the extended care portion of the homes for the aged the 1.5 hours per day is the--

Mr. Corder: They have to make application and are eligible for extended care benefits as any other extended care (inaudible). They require 1.5 hours of nursing care per day.

15:40

Mr. Andrewes: And then the per diem becomes identical?

Mr. Corder: I understand that the budgetary arrangements for homes for the aged are handled on a different basis than the per diem arrangements are. They are handled on a budget arrangement, as I understand it. The municipal level shares with the province on some sort of percentage basis, with a consideration of deficits as a separate issue at the end of the year. Then if you convert that into a per diem, I suppose it is--

Mr. Andrewes: Let me deal with a nonprofit, say, a home for the aged run by a church organization. Is that copayment identical? There is nobody picking up the deficit there. It has to be a self-sustaining organization, as far as I understand it.

Miss Stephenson: (Inaudible) deficit has been picked up.

Mr. Reid: In charitable homes for the aged?

Mr. Andrewes: Charitable homes for the aged.

Mr. Reid: The copayment payable by the resident is identical to--

Mr. Andrewes: That was really my question. And the level of care, the qualification to get into extended care is identical?

Mr. Corder: Identical.

Mr. Reid: You are admitted to a home for the aged under the same program as you are admitted to a nursing home, the same eligibility requirements. In fact, all the eligibility is done by the Ministry of Health.

Mr. Andrewes: Are the rules the same?

Mr. Reid: Rules of what?

Mr. Andrewes: In terms of the criteria for the inspections that are applied to nursing homes? Are similar criteria applied to homes for the aged?

Mr. Corder: I cannot answer that directly, but I understand that there is a component involved in the homes for the aged and in charitable institutions that we do not have in the nursing home sector, and that is local accountability, handled through the municipalities and their accountability to the electorate. However, as far as I know, they are not subjected to inspection processes per se handled at the provincial level.

Mr. D. S. Cooke: The Ministry of Community and Social Services will go out to a home for the aged if it receives a complaint.

Mr. Corder: I am afraid I am not knowledgeable in the Ministry of Community and Social Services area.

Miss Stephenson: Concerning the space requirement per resident, the window requirement and the air circulation--all the lovely features you developed in 1972 that made some of the smaller nursing homes close down because they simply could not comply--are all those required of the extended care portions of the homes for the aged?

Mr. Corder: I do not believe they are, but you would be better to direct that to the Ministry of Community and Social Services. They will be coming, will they not?

Miss Stephenson: Tomorrow. Do you have a ball-park figure of the degree of provincial support on a daily basis for a residence in the extended care portion of a home for the aged?

Mr. Corder: I believe the per diems I have heard talked about range between \$60 and \$80.

Miss Stephenson: Plus a participation equal to that for a nursing home resident as the patient component.

Mr. Corder: That is my understanding.

Mr. D. S. Cooke: Is it fair to say there are totally different financial arrangements between homes for the aged and the Ministry of Community and Social Services and nursing homes and the Ministry of Health? You pay for a service and you expect and assume that the service is going to be fulfilled, and that is as far as your responsibility goes with the money. Homes for the aged have to submit budgets and they have to get budget approval. The government knows how much money is being spent on recreation programs, on food and on salaries. All that stuff is broken down, but none of that exists for nursing homes.

Mr. Andrewes: Not in charitable homes for the aged.

Mr. D. S. Cooke: Charitable homes for the aged have to submit budgets.

Mr. Andrewes: To the Ministry of Community and Social Services?

Mr. D. S. Cooke: Sure, because 80 per cent is picked up by the government. The only thing the charitable homes have to pick up is 20 per cent.

Mr. Corder: It is fair to say that the money approach is different in both. There is a budget approach in the sector you just discussed and there is a negotiated per diem approach that the Ministry of Health has with the nursing home industry.

Mr. D.-S. Cooke: Could you get us statistics on how many complaints are lodged against nursing homes on an annual basis? Is all that information kept up by your inspection branch? How many charges are laid against homes, those that go to court, the average fine and the kind of information that would give us some inkling of what the enforcement is like?

Mr. Corder: I am sorry. I cannot.

Mr. D. S. Cooke: Do you know offhand how much the inspection branch and the enforcement of the Nursing Homes Act costs the ministry?

Mr. Corder: Off the top, I do not.

Mr. D. S. Cooke: That figure never shows up in the per diem.

Mr. Baetz: Is it safe to assume that each and every complaint lodged against a nursing home is looked into and followed up by someone from the ministry?

Mr. Corder: Yes, it is.

Mr. Baetz: Can one say that without equivocation?

Mr. Corder: One can say that without one worry that it is not true.

Mr. Sargent: As we go through each department, are we making any resolution at that point, or are we going to leave all this to the end? What are we going to have at the end? We cannot backtrack and know what we have discussed. Are we going to have any finalization at the end of each subject?

The Acting Chairman: The purpose of the briefings this week is to allow us to be informed on the status quo regarding the involvement of the private sector in health care and community and social services. In the light of--

Mr. Sargent: Why do you not send us all home with a book and let us sit and read it?

The Acting Chairman: It was felt that some might wish to--

Mr. Sargent: Oh, the per diem rate.

Miss Stephenson: The extra billing of the members of the Legislature.

The Acting Chairman: We will also be talking with our consultants on Thursday and Friday about how we wish them to proceed. It was felt we would need some background before we could do that. Are there any further questions for Dr. Reid or Mr. Corder?

Mr. Reid: I just got a promotion.

Mr. D. S. Cooke: Coming from the Ministry of Health, you automatically assume that is a promotion.

Miss Stephenson: When you are a member of the Legislature, you look at it the other way, when you listen constantly to the man behind me.

Mr. Reid: When you start out as an accountant, anything is a promotion.

The Acting Chairman: Thank you very much for your presentations. To the members of the committee, the clerk advises me she has received briefing books from the Ministry of Community and Social Services. She wishes to know whether the members would like to have them this evening to prepare themselves.

Miss Stephenson: Are they this size?

Interjection: Do you need a trolley to take it home?

The Acting Chairman: Mr. Sargent, you may wish to consider your suggestion. I gather no one wishes to receive them this afternoon.

Mr. D. S. Cooke: I think Eddie should take it home, read it and give us a synopsis tomorrow morning.

The Acting Chairman: If there is nothing further, we will adjourn until 10 a.m. tomorrow.

The committee adjourned at 3:52 p.m.

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85H21

SELECT COMMITTEE ON HEALTH

COMMERCIALIZATION OF HUMAN SERVICES

WEDNESDAY, AUGUST 27, 1986

Morning Sitting

SELECT COMMITTEE ON HEALTH

CHAIRMAN: Callahan, R. V. (Brampton L)
Andrewes, P. W. (Lincoln PC)
Baetz, R. C. (Ottawa West PC)
Cooke, D. S. (Windsor-Riverside NDP)
Johnston, R. F. (Scarborough West NDP)
Poirier, J. (Prescott-Russell L)
Polsinelli, C. (Yorkview L)
Reycraft, D. R. (Middlesex L)
Sargent, E. C. (Grey-Bruce L)
Stephenson, B. M. (York Mills PC)
Turner, J. M. (Peterborough PC)

Substitution:

Dean, G. H. (Wentworth PC) for Mr. Turner

Clerk: Deller, D.

Staff:

Fooks, C., Research Officer, Legislative Research Service

Witnesses:

From the Ministry of Community and Social Services:

Duda, C., Assistant Deputy Minister, Community Services Division
McCartney, J., Policy Analyst, Disabled Persons and Employment
Services Unit

LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON HEALTH

Wednesday, August 27, 1986

The committee met at 10:06 a.m. in committee room 2.

COMMERCIALIZATION OF HUMAN SERVICES
(continued)

Mr. Chairman: I understand in my absence yesterday we got a briefing by the member from Owen Sound on what he would do with relatives and Extendicare.

The next item is public hospitals, is it?

Clerk of the Committee: No. We are on to the Ministry of Community and Social Services.

Mr. Chairman: All right. We will get into the small book you have before you.

Mr. D. S. Cooke: We did not get into one item on the agenda, the election of a new chairman.

Mr. Chairman: I think there is a plot. Michael treats me badly too. Last night he treated me badly.

Clerk of the Committee: From the Ministry of Community and Social Services, we have Gerry Duda. There are amendments to the book.

Mr. Chairman: You have before you a smaller loose-leaf book which we are going to go through. There are also a number of pages that are clipped together. These are amendments to the book. We have before us this morning Mr. Gerry Duda.

Mr. Duda, how are you? Will you tell us who is with you?

Mr. Duda: Yes, Mr. Chairman. I have with me a few staff members. When I run into problems, I hope they will provide me with additional information. To my right is Donna Marafioti, who will be helping with the presentation. Behind me are Shirley Cooper, Martha MacLean and Jean McCartney.

As you mentioned, Mr. Chairman, the summary of our programs is provided in the black binder. There are a few pages that are in addition to what we have already provided. The presentation this morning will highlight the information you have in the binder. We will be taking you through it. It is very much an overview. I notice the mammoth binder from the Minister of Health; our information is dwarfed by the information it provided.

Mr. Chairman: We were going to comment on that.

Mr. Andrewes: So is your budget.

Mr. Duda: So is our budget, yes.

Mr. Chairman: You are more succinct in your presentation.

Mr. Duda: I think it is a function of our quality.

Once we get through this morning's session and possibly this afternoon, you may require additional briefings. As we go through this morning's information, you will note the majority of our programs are provided through the not-for-profit sector. There are some that are still significant, which are provided through the for-profit sector. Basically, the two largest of these are the children's boarding homes and child care or day care.

The content of the presentation includes a summary of the request from the select committee, a display of the organization of the Ministry of Community and Social Services, an overview of our size and spending and the definition we were asked to use in separating the not-for-profit from the for-profit.

A chart outlines our funding relationships along three lines: the services we fund through agencies, the services we offer directly and the services that are delivered through municipalities.

We are going to elaborate on the nature of the relationship among the ministry, agencies and municipalities, particularly as requested: children's services; services to the disabled, dwelling on those that are delivered through the for-profit sector; elderly services, the majority of which are through the not-for-profit sector, but you probably require that information and you have requested it; child care or day care; and a range of smaller programs grouped under the title of family support.

Mr. Chairman: Dr. Stephenson just came in. We are on the small binder. Those are actually amendments to the small binder.

Mr. Duda: Our ministry and the Ministry of Health have been requested to provide information--and I have underlined those that pertain to the Ministry of Community and Social Services--in the following areas: care for the elderly; some alcohol rehabilitation programs; obviously, social service facilities that are operated in the private sector; and, last, children's services.

This provides you with an overview of our organization. In the section outlined in red are the two newly created program divisions. The services I will be describing this morning and possibly this afternoon are related to these program divisions, namely, children, the elderly, services for the disabled, family support and child care.

Mr. Chairman: Are these things reproduced in our loose-leaf binder?

Mr. Duda: Yes.

Mr. Chairman: It might be helpful if you refer us to the page on which the slide is being presented, so that if someone does not care to watch, he can look through his binder.

Mr. Duda: In the introduction, the format is a little different, because some of the words have been reduced for slide presentation purposes. All the information in the first five or 10 minutes is in the introduction in the black binder.

Mr. Chairman: Is there a copy of that diagram?

Mr. Duda: Other than the reorganization chart, no. I thought at the last moment it would be helpful, but if you want hard copy--

Mr. Chairman: Perhaps you could supply that to us. I think it would be helpful to the committee.

Mr. Duda: Okay.

Mr. Chairman: It lets us know whom to go to.

Mr. Duda: On page 3 of the binder, we have summarized the expenditures in the Ministry of Community and Social Services and the staff size. We have a staff of slightly over 11,000, a 1985-86 operating budget of \$2.9 billion and an estimated budget of \$3.1 billion in 1986-87. It is divided into the following areas: income maintenance, employment services and family support, \$1.4 billion; children's services, \$524 million; services for both the developmentally and physically handicapped, \$454 million; adult services, which include services for the elderly, homemakers and nurses' service programs, \$349 million; and resources and administration, \$60 million. That rounds off to approximately \$2.9 billion.

This is not in your documentation, but we thought for purposes of discussion it might be useful to have an operational definition of "for profit" in contrast to "nonprofit."

In terms of the nonprofit, many of our programs are delivered through incorporated charitable organizations and municipalities and some through individuals who provide services as volunteers, namely, foster parents. For purposes of this presentation, foster parents who receive stipends for out-of-pocket expenses are not considered for profit.

In terms of the profit-making enterprises that provide social services, we have included businesses that are incorporated as profit-making, professional service providers, many of whom are individuals such as psychologists who in the broader definition of "for profit" may be considered as providing them for a profit, and some individuals who are not incorporated who are providing services for profit. Throughout the presentation, you will see reference to nonprofit as opposed to profit, and this is the operating definition we are using.

In the black binder, we have included a breakout of our expenditures by program type and grouped them under three categories. The first category is those services provided by agencies. As you can see in the overhead, that is more than \$700 million worth of services. That is in both children's programs and adult programs, including the aged and services for the handicapped.

10:20

It is important to point out that each of these three service modalities, in turn, purchase service. For example, the children's aid societies purchase group home spaces in children's boarding homes, most of which are for profit. On the other hand, we have a new integrated homemaker program that is being introduced through the home care units, and in some cases they purchase homemaker services from for-profit agencies. In this case, we fund the agencies. I will be elaborating on that bottom box as we go

through the presentation. The agencies, in turn, exercise their discretion and purchase residential services and some homemaking services from for-profit agencies.

The ministry itself provides a wealth of services, the majority of which are family benefits and schedule 1 facilities for the mentally retarded. We too purchase service from other agencies or groups. We contract group homes for youthful offenders and professional services from time to time under our special needs services in both phase 1 and phase 2. I will be elaborating on that.

By the way, these totals are cumulative from the three modalities.

Last, we deliver a number of services through municipalities, the largest of which are the general welfare assistance program and municipal homes for the aged, as well as child care. As you will note, municipalities exercise discretion in purchased services themselves. I will ask you to add spaces in satellite homes for the aged to those they purchase. Again, the same principle operates. We provide resources to municipalities that have the discretion either to operate the services directly or to purchase from other agencies. In some cases those organizations are for profit and in other cases they are not for profit.

Maybe this will be somewhat helpful in laying down some groundwork on the principles we use, if they can be called that, when applying the resources of the Ministry of Community and Social Services. As you probably are aware, the ministry is large and diverse and serves many populations. We are concerned that those services are delivered through a network that is effectively managed and accountable, leading to quality, locally responsive--and that implies there should be some agency municipal discretion around how they may provide those services--and delivered in the most efficient manner possible as value for dollar.

While one cannot provide a comprehensive rationale for each and every one of our programs, this seems to capture the nature of our relationship with our agencies and, by way of principle, provides them with some autonomy and discretion whereby they make choices. Sometimes those choices are to purchase service from for-profit organizations.

We use a number of accountability mechanisms, so that the quality I spoke of a minute ago is adhered to or is attempted to be reached. Some of them are legislative; others are the usual budgeting processes. We have a service plan, which is a form of planning and budgeting applied to children's aid societies, children's mental health systems and, soon, the mental retardation system.

Many of the Ministry of Community and Social Services programs are funded on a claim basis. Municipalities and charitable organizations, namely, homes for the aged, provide monthly claims for their expenditures and the number of services provided. In many ways, that provides us with a very clear point of accountability.

In contrast to the Ministry of Health, we also have a very decentralized operational division. We have 165 program supervisors in 13 area offices who have frequent contact with the many agencies. From memory, there are about 1,800 agencies in the municipalities we fund. As we go through the presentation, you will note and see that we have guidelines or program manuals in most program areas.

I will show you this. It is in your binder. In case you want any of our manuals during your hearings or your deliberations, a list of them is provided. It may be useful in terms of any one critical area that you think is worth pursuing. It is at the back of the book.

The first one is children's services. The three areas I think you will probably be concerned with in children's services, other than child care--and I will get to that in a little while--will be children's boarding homes, foster care--there are a few independent for-profit operators--and contract group homes, which are purchased for youthful offenders.

The first one is verbatim. It is taken right from the book. I have highlighted some of the critical areas in red. This morning maybe we can hit the highlights.

Children's boarding homes are operated primarily by the for-profit sector. Ninety per cent of the beds are offered through that modality. They are services that are usually provided to wards of children's aid societies. We fund the children's aid societies. They, in turn, can provide residential services themselves or they can exercise their discretion and purchase them from a private operator.

Each one of those homes is licensed by the Ministry of Community and Social Services. Should you require it, we can provide you with our licensing manual. It gives all the criteria and procedures in terms of licensing.

Mr. Chairman: Could I interrupt you for a second? Those pages he is referring to are the first two to be changed in here.

Mr. Duda: The other thing I might say is--and this is probably subject matter for another presentation, should you want to pursue it--is the rate-setting exercise in the proprietary group homes. During the 1970s, there was a rapid expansion of this service sector driven by the number of adolescents at the time. That was a function of demography, with the numbers of baby-boom people going through their adolescent years. As a result, there was a demand on children's aid societies, which, in turn, purchased many services.

Because of that fact, it began to be a bit of a seller's market and the rates began to increase very quickly. As a result, we froze every rate and would not share with children's aid societies any cost incurred when they purchased a service from an agency which charged more than the frozen rate. If the operator was concerned that the rate was inadequate, we had a rate review process. Through that, there was some financial disclosure and determination of the costs associated with providing the program, plant, food and staffing. Staffing is about 60 to 80 per cent of the cost. Through that, we determined what seemed to be a fair rate. That was done in the late 1970s.

Over the years, the increase to the rate has more or less been a function of the economic adjustment each year--three, four or five per cent. In those cases where an operator felt there was some justification to raise the rate beyond what he had historically been receiving, we would have a rate review process.

Any new operator provides financial information to the ministry, actually to our area offices. At that level, we approve a rate. The rates are not provided in your information. They range from the lowest of \$36 to the highest of just less than \$100, but for the most part, the averages are around \$65.

10:30

I should mention that the children's boarding home system provides services for children who have variable needs. They are different from child to child; in fact, with individual children they vary from month to month and even from day to day. For example, you may have a child who is withdrawn and quiet and who does not seem to respond in a traditional family setting. For clinical reasons it is determined that a group setting may be more appropriate. That child may require the average amount of attention; in other words, additional staffing will not be required because he is not likely to run away or act out.

On the other hand, you may have children in the system who are disruptive and prone to acting out or running away. In those cases, the costs may be higher because of the staffing requirement to provide services to the children. The underlying reason for variable rates is variable needs. As you will note, there are 157 homes across Ontario providing services through 1,509 beds.

Mr. Chairman: Does that include those under the Young Offenders Act?

Mr. Duda: No. I am coming to that.

Mr. R. F. Johnston: I cannot remember off the top of my head the difference in the numbers of these homes now compared with eight to 10 years ago. There has been a substantial drop in the the number of beds, has there not?

Mr. Duda: Yes. I do not have it with me. Probably, 1975 to 1985 would be a good basis of comparison.

Mr. R. F. Johnston: That would be great.

Mr. Duda: With regard to foster care, the majority of fostering is provided through the children's aid societies, which of course are not for profit. They provide services to approximately 20,000 homes. However, they sometimes purchase foster care services from independent operators. I understand there are four foster care systems in the southwest region of Ontario with a modest amount of beds, 20 beds out of 5,000. We thought we would bring that to your attention, although I do not know whether it is as significant as a boarding home.

Before I begin on the contract group homes and the Young Offenders Act, we have some data missing from this; we are going to have to provide it later. One is the number of contract beds that we purchase under the Young Offenders Act. It is available. Unfortunately, when we started the data collection exercise two weeks ago, we got most of everything but this. We will have it and provide it to you in a couple of days.

These homes, much like the boarding homes, are licensed. In fact, the very same standards are used. Services are purchased under the Young Offenders Act from these homes for secure and open custody and, from time to time, with a probation and an order to reside. Obviously, their rate is set with the probation and after-care services area office, and they are purchased as required. I will have to get you the data later. It is quite a bit smaller than the boarding homes. Unfortunately, I do not have it today.

The next section is on services to the disabled. Before I begin, I should outline that most of the services for the disabled are offered through the not-for-profit sector, which in turn purchases auxiliary services from the for-profit sector.

Services to the disabled involve the attendant care services program; the approved home program; the community-based support services program for the mentally retarded; the family home program for the developmentally handicapped; the group homes for the developmentally handicapped program--a couple are for-profit homes--the special needs and services program, individually purchased services for purchase on behalf of individuals from professionals; and the vocational rehabilitation services program. I will go through each of these.

First is the attendant care services program. Throughout Ontario, a reasonably new service is called the attendant care program. It provides personal care and homemaking services to severely severely disabled adults in designated apartments. These individuals are usually quadriplegics or severely handicapped paraplegics.

The attendant care services fund nonprofit agencies. However, from time to time when there are staff shortages or sicknesses they hire attendant care staff from private, for-profit organizations such as Para-Med or ComCare, but in the main their services are provided on a not-for-profit basis. In our estimation, out of the \$10 million spent in 1985-86, \$110,000 was spent on purchased services from private, for-profit organizations.

The next program is the approved home program. An approved home program is an extension of a facility for the developmentally handicapped. In many ways, it is like a foster home where there are a few individuals being cared for in a family-like setting. The majority of them, by their nature, can be considered as for-profit. It is quite a small program. There are 40 homes and 71 clients. We do not have the data in terms of which ones are for-profit or not-for-profit. I think their per diems are in the \$20 range; that implies that most of the operators are families providing services to individuals. Given the \$20 per diem, I do not think there is much opportunity for profit-making.

The reason we have included it is it is somewhat higher than foster care rates. It is more than just out-of-pocket expenses. It would provide some compensation for the shelter as well as for the food that is provided.

Mr. Chairman: What is the foster care, as a matter of curiosity?

Mr. Duda: I will have to get back to you, because I would be guessing. I think it is about \$400 a month.

Mr. Chairman: It is \$400 a month.

Mr. Duda: Yes. It depends on the needs of the child and the age of the child. Adolescents receive more than younger children. If they have special needs above and beyond that--I will have to get you a breakdown on the foster care rates.

Mr. R. F. Johnston: I would like to be clear on how we are going to proceed. There are any number of incidental questions such as that around any of these items that I would have as we go through them. I wonder whether we are going to go through the entire book and then come back to each of the

sections and go through them. It is probably not wise to do it with each individual subsection such as this, but when we are dealing with a children's section can we go back and do questions on it? On my list there are going to be about 20 or 30 questions by the time we get to the end.

Mr. Chairman: I thought that on the first day we adopted doing a section and then asking questions. Perhaps we will follow the same procedure. If you like, we will finish this one and then we can go back and do the first two. Is that agreeable to the committee? Okay.

Mr. Duda: The next is community-based support services for the developmentally handicapped. This part of the service sector or elements is approximately 12 years in development. When services for the developmentally handicapped were transferred from the Ministry of Health to the Ministry of Community and Social Services, we began to create a range of community support services such as infant stimulation, respite care and behavioural management, all of which were provided to children and adults living in the context of the community.

All the services are funded through nonprofit agencies, the majority of which at the local level are through the local association for the mentally retarded, some municipalities and other social service organizations. For each of these programs, we have guidelines directing the professional management of these services. There are some very limited profit-seeking opportunities and it is usually when the nonprofit agencies purchase an occasional psychological service from a profit-making agency.

10:40

The family home program is a few years old. It provides a supportive, home-like atmosphere for developmentally handicapped persons but provides some training and supervision of that individual in the community. It is considered more intense and demands more than a foster parent, because there are some developmental needs of the individual that have to be met. As a result, it is funded at a rate at which one could not consider the individuals as strictly volunteers. For that reason, we have considered some of those individuals to be in the profit-seeking role. However, the family support or family home agencies we fund engage those private operators; we do not do it directly. At present, the program has 136 clients residing in 99 homes across the province, and they are operated by 16 family home agencies.

Since 1974, paralleling our development of nonresidential services in the community, there has been a tremendous growth in group homes for the developmentally handicapped. We estimate there are close to 3,800 beds in the community. A few that are providing services are funded as profit-making agencies. On page 2 of this section you will note that those that provide services on a for-profit basis involved a total expenditure of \$658,000; they are the Mallorytown, Oxford Mills and Merrickville residences in eastern Ontario.

It is my understanding that it is in the absence of any nonprofit interest, agencies or organizations being interested, the funds are provided to the profit-making agencies. In total, there are approximately 20 to 30 beds in the profit-making homes. The number of clients served in the nonprofit group homes is 3,774. Obviously, the majority is provided through the nonprofit agencies.

We have a program in the Ministry of Community and Social Services known as special needs and services. Basically, this is a program that provides auxiliary services to individuals in residential care or children living with their parents who cannot obtain the necessary services. They are individually applied service contracts that provide things such as behaviour training, life skills, physiotherapy, infant stimulation and equipment. This program was introduced in 1981. Phase I was introduced to the residential settings, and phase II was the nonresidential.

If I may, I will go over to the summary of phase II. It is in the additions you already have. I think it is one of the supplemental sheets. Some of the services offered to the clients in phase II are provided through the for-profit sector, the majority of which involve individual professionals who provide the speech therapy, physiotherapy or behaviour training. In the whole of phase II we have 745 service contracts, serving 744 clients. The profit-seeking sector receives \$170,000 out of a total budget of \$5.9 million.

Below that we have some examples of those profit-seeking organizations that receive funding for special services at home. They are separated by the geographic regions of the ministry: southwest, southeast, central and north.

In the handicapped area, we also provide services to clients in nursing homes and homes for special care. The Ministry of Health provides the basic services, the per diem for the daily care of the individual. We provide services above and beyond that, things such as speech therapy, behaviour training, etc.--professional services for the most part. In those cases, we fund agencies which in turn provide services in the nursing homes or in the homes for special care for the developmentally handicapped individuals.

We have a manual that governs the administration of that program. Some of the services are provided through the nonprofit sector and some are provided through the for-profit sector.

Much of this care is provided by individual professionals. However, a couple of nursing home operators have received contracts from the ministry to provide services. For the most part it is individual professionals, but there are others. On the next sheet, in the attachments, there is an elaboration of that. It is another addition. The total budget of the triministry service is \$9.2 million. There are 14 contracts with for-profit operators, 12 of which are with nursing home operators. I believe that is for service co-ordination.

Mr. Chairman: Which one are we at? I do not see it.

Mr. Duda: Pardon?

Mr. R. F. Johnston: I do not see the triministry addition.

Mr. Chairman: I do not where it is.

Miss Stephenson: The triministry addition is in the book.

Mr. R. F. Johnston: I do not have that page; sorry.

Mr. Duda: The one up there is just a summary.

Mr. R. F. Johnston: Okay.

Mr. Duda: It is on page 2. The contracts with the nursing home operators and the two contracts with management and consulting groups amount to \$1.8 million, which is a significant part of the \$9.2-million budget. Services to 850 people are provided through those 14 contracts.

The last one before we get into a discussion is the vocational rehabilitation services program. This service is provided directly by the ministry and is 35 years old. It provides vocational counselling and purchases vocational services on behalf of disabled adult individuals. Throughout our network of area offices we have vocational rehabilitation counsellors who process the requests for services from handicapped or disabled individuals. The kinds of services we provide are counselling, assessment, the purchase of training opportunities and the purchase of assessment services. That would include purchase of skill training and sponsorship and maintenance allowance during post-secondary school.

Again, because of the nature of the program and because we have to purchase some professional services and some equipment--I might say there are equipment restoration services provided. On page 2 there is a list of those things that may be provided through the for-profit sector.

Under the VRS program an educational institution is mentioned. This is the program we provide for the learning-disabled child through VRS. Most of this program will likely be and is being replaced by the Bill 82 initiatives in the Ministry of Education. Some of those schools are on a for-profit basis; some of them are outside Ontario.

That provides to this point a summary of the Ministry of Community and Social Services and our size and expenditures, the nature of our funding relationships with agencies and the services we offer directly and through municipalities.

By way of summary, most of the services that are purchased from the for-profit sector are done indirectly. In other words, agencies purchase them and they are not for profit in themselves or for municipalities. The largest one mentioned to this point is the children's boarding home area. What may be of some significance is the triministry project that spends \$1.8 million through profit-making organizations.

10:50

Mr. Chairman: Are there questions?

Mr. R. F. Johnston: There are a couple of philosophical things and the rest are mostly additional statistical information and then particular information about owners of profit-making agencies that are involved with the ministry.

First, in deciding whether you fund profit-making agencies--forgetting other groups that do not have the capacity to do psychological assessment and that kind of thing and purchase services indirectly--in the provision of services in the group homes or boarding homes area, what is the philosophical position of the ministry in terms of what is to be provided through the nonprofit or the profit sector? You made your distinction between what each of those is, but what is the philosophical position of the ministry on whether it funds profit or nonprofit?

Mr. Duda: I would be exaggerating if I said we had a coherent philosophy applying to all those programs. We do have some rationale and I can share that with you.

Most of the relationships are somewhat historical in nature. First, the children's boarding home area has a fairly long history but the bulk of it developed through the 1960s and 1970s. As a result, because of the demands to provide services, the children's aid societies turned to other agencies for residential services.

I guess our philosophy is inherent in our relationship with agencies and municipalities, which allows them to exercise discretion in terms of who they may purchase from. Given that the individual needs of a child are unique, they are in the best position, given their professional competence, to determine the needs of that child. Some of the choices they have are the services they provide or turning to other service systems to provide those services.

Some children's aid societies provide a good part of their residential services through their own system. One that comes to mind is the Ottawa CAS. Most of the others purchase--as I remember, there are 15,000 beds--from the boarding home area, which is predominantly for profit.

If there is a philosophical principle to be applied, it is the protection of municipal and agency discretion in making choices on behalf of the clients they serve. At the same time, we recognize that we have some significant responsibility in terms of the quality of services. That is why in the late 1970s and introduced, I believe, in 1980, we instituted a whole set of standards for children's residential programs that apply not only to boarding homes but also to every children's residence, whether it be a children's mental health facility or a boarding home situation.

Additionally and along the same lines, we applied that same principle in foster care. We have foster care standards that are applied, and we license agencies to provide foster care and let them make choices. We do not license individual homes. Predominantly, societies have chosen to provide foster care services themselves. In four instances, as I remember, 20 to 30 beds are provided through the for-profit sector. It is more an operational principle, rather than a principle of program value, that operates and determines the approach we have taken.

We will be looking at child care later and it is entirely the same principle that is being applied. Municipalities are provided with resources and they make choices. A significant number of times the choice is to provide services through the commercial sector.

Mr. R. F. Johnston: Thank you. I asked the same thing of the Ministry of Health yesterday to try to get some idea of whether there was a current policy. Can you get us a list of the for-profit boarding home owners?

Mr. Duda: Yes.

Mr. R. F. Johnston: Are any of them chains? If any of them own more than one institution, could we have an idea of that corporate ownership and the size of the chain?

In addition, I would appreciate it if we could have a look at that change and at the drop in numbers of beds since 1975 that we talked about, which resulted from the different policy of the ministry towards the funding of children's aid societies.

It might be best, if other members have questions on this, to hear from them.

Mr. D. S. Cooke: Is there any financial accountability for boarding homes? Do you ask for budgets?

Mr. Duda: Typically, in situations where services are purchased by agencies in municipalities, there is no financial disclosure requirement. The agreement is between the agency and the provider of service. However, in the boarding home area, because of the rapid growth in the middle 1970s as a response to an excessive demand at that time, prices increased rapidly and we instituted a rate review process.

Each rate that was increased beyond the economic adjustment required a submission to the ministry to set the rate. That involved a budget displaying costs, which ultimately reflected in the per diem, the cost for shelter, food, staffing and utilities. Any new operator has to submit that information as a method of setting the rate, so there was some financial disclosure.

Mr. D. S. Cooke: The only time that would be required is when there are negotiations or discussions for a change of rate; which happens how often?

Mr. Duda: It happened more often in the late 1970s; it does not happen so much any more.

Mr. D. S. Cooke: It happened when inflation was--

Mr. Duda: For two reasons. Demand has dropped off and we control expenditures a little more carefully in CASSs, so they are more cautious in spending their money. In addition, the very factor of disclosure is a disincentive for some. I do not know that for certain, but I assume they prefer not to go through the mechanism of requesting a rate change.

Mr. D. S. Cooke: How profitable are some of these places?

Mr. Duda: You are asking me the most difficult question of all. I have made a number of inquiries around the level of profit allowed. We look at each of those categories I mentioned and at what the reasonable costs are in terms of salaries, and we have standards of food and shelter. Beyond that, we establish a rate that allows for a small profit.

It might be useful, if you want to elaborate on that, to go through the rate-setting manual, which is quite complex, and see the considerations made in setting the rate. From my memory of some years ago, when I was involved in rate-setting exercises, in the individual homes with which I was involved the allowable profit was not all that significant.

Mr. D. S. Cooke: What does that mean?

Mr. Duda: It might be in the range of five to 10 per cent of gross operating expenditures.

Mr. D. S. Cooke: Are the documents that are filed when rates are being reviewed public documents or are they confidential within the ministry?

Mr. Duda: First of all, the rate review manual is available, but I think you are asking specifically--

Mr. D. S. Cooke: I am asking about specific submissions from boarding homes.

Mr. Duda: I doubt whether they were a function of our relationship with our individual operators. I am hesitant because I am trying to think of the information disclosure provisions and whether they might or might not be.

Mr. R. F. Johnston: Where the group homes are privately run, is there not considered to be an agreement between the agency and the operator that they are not publicly disclosed?

Mr. Duda: Yes, that is right.

11:00

Miss Stephenson: I recall vividly the battles we had, which we did not win, to persuade the operators of a so-called nonprofit chain of such homes for children to reveal anything related to the amount of money that was being accumulated, which was being spent by the operator in the purchase of very large cars, yachts, farms, properties overseas and all kinds of things.

Interjection: That was Brown, I think.

Miss Stephenson: Mr. Brown. Yes, Mr. Brown. Right.

Mr. R. F. Johnston: We had a case this spring of a group home in Kingston that was closed down for good reason and for which we still do not publicly have the financial information. They have not had financial accountability for eight or nine years.

Mr. D. S. Cooke: It is the policy, then, that these budgets are not released. I wonder whether the committee can request that. Obviously, there has been a change in the philosophy of one ministry, since there are going to be amendments to the Nursing Homes Act to provide for financial disclosure of budgets and so forth, publicly disclosed, publicly posted in each nursing home. Obviously, the government has a different philosophy now. Would it not be appropriate for the committee to ask for some of that material to see whether we can get an inkling of some of these budgets?

Mr. Chairman: Within the terms of reference, we are looking at the question of the commercialization of health care and social services and I think that would be a relevant consideration. Since there is no legislation requiring it, it would have to be done on an in camera basis and on a totally confidential basis.

Mr. R. F. Johnston: There are two sides to it. One would be to try to deal with it that way. The other would be to make it one of our recommendations. It raises the whole question of how well we can look at the effectiveness of this particular side of the sector without knowing what the financial implications really are.

Mr. Chairman: Perhaps we could ask. I think it should be on a confidential, in camera basis.

Mr. D. S. Cooke: We can do it that way if we have to. My own reaction would be that if it has to be done on a confidential basis, I would rather just make the recommendation that the whole process be opened. The information would be nice for us to see, but the point still is that it should not be available only to members of the select committee on a confidential basis, it should be available to the taxpayers of this province. It is their money.

Mr. Chairman: As I see it the purpose of this committee is to determine whether we should provide services through the public sector or the private sector--

Mr. D. S. Cooke: One of the questions is accountability.

Mr. Chairman: --and to look at the question of cost sensitivity and delivery of service. We are not really here to do an examination of what profit the people who are engaged in the business are making, simply for the benefit of--

Mr. R. F. Johnston: No, accountability.

Mr. D. S. Cooke: It is the accountability question, Mr. Chairman. Do taxpayers have a right to know how effectively their money is being spent and where it is being spent, whether it is going into profit and \$2 a day on food or whether there is adequate provision of services and still enough money to provide profit? You cannot really do that if the books are not open.

Mr. Chairman: Maybe I can find out from the other members of the committee at this point how we plan to deal with this.

Mr. D. S. Cooke: It is a very fiscally responsible, very conservative approach to taxpayers' money.

Mr. Chairman: It may be, but I still feel personally it is something this committee should look at on an in camera basis, on a confidential basis, since, as I understand it, there is no enabling legislation that requires, first, that they file it publicly and that it be made available publicly.

Mr. D. S. Cooke: I would like to see a copy of the policy on how this material is handled by the ministry, and then perhaps the committee could again discuss how the information could be handled after we have seen a copy. We do not need enabling legislation. It depends on what the policy of the ministry is. Let us ask for a copy of the written policy and, after we have seen that, go from there.

Mr. Chairman: Any problem with that, Mr. Duda?

Mr. Duda: No.

Mr. Chairman: Perhaps that is the way to cut this off at the pass.

Miss Stephenson: If we go in any direction of this sort or even suggest we are moving in that direction, can we ensure that the same rules apply to all agencies, including some of those that function under the guise of not for profit? There are definitions of profit which apparently are not precisely delineated in the minds of some people.

Mr. Chairman: Yes. Mr. Johnston, do you have any more questions?

Mr. R. F. Johnston: It came down to quality of service, going back to what you were just mentioning. Jerry, you made some comments about the huge range of needs of kids of these homes. One of the things that concerns me is that the standards for the homes are quite different, even though they may be dealing with kids with severe emotional disabilities. In my view, they are often dealing with kids who are as hard to serve as children in the children's mental health centres, if not harder. The expectations of the home are quite different and the funding is very different.

Has the ministry done any kind of an analysis contrasting or comparing those two kinds of services--who is being served, the quality of the care being given and that kind of thing--that the committee can have a look at?

Mr. Duda: No. There has not been a comparative analysis of the client characteristics of the two systems. The same regulated standards are applied to both sectors, but undeniably the children's mental health sector has many more professional services. It is not unheard of that per diems are in the \$100 to \$250 range, whereas in the children's boarding home area it is an average of \$65 more or less; \$60 to \$80.

Mr. R. F. Johnston: But you would not disagree with me that some of the clients in a boarding home may have problems that are as severe as those of a child in a children's mental health centre.

Mr. Duda: I would say they are severe, but typically they would use children's mental health facilities as professional backup or use them from time to time if there were--

Mr. R. F. Johnston: Day care services.

Mr. Duda: Yes, day care services or professional consultation. Their needs tend to be longer term. The average length of stay in a children's mental health residential treatment facility--I think most youngsters are out in nine months.

Mr. R. F. Johnston: It would depend on the age group. The 12-year-olds are in for an average of two and a half years.

Mr. Duda: It depends on the age group. I am just giving you an average.

I do not have data with me, but from memory and experience the children's boarding homes, on the other hand, are longer term than nine months. The two and a half years you mentioned with the 12-year-olds are more likely the kind of factors and the length of stay of a child in a children's boarding home.

Mr. R. F. Johnston: I wonder whether we could get that kind of contrast of the clientele and the program. It seems to me that kids in the boarding homes are older than some of the young children we have in children's mental health centres who have the shorter-term stays. A comparison would be more appropriate between the 12-year-olds and 13-year-olds in both systems.

I am concerned that we have such a large discrepancy between the funding and the expectations of the two systems when we know the clientele has changed dramatically since the early 1970s when the children's aid societies were putting all sorts of kids with fewer problems--maybe occasional runners or that kind of thing, but not severely disturbed kids--into these kinds of placements. The clientele has changed quite dramatically, and I am not sure that our legislation and standards have particularly.

Mr. Duda: We will give you the information we have. I might say, though, a children's aid society would consider two things in placing a child. It would obviously consider the clinical needs of the child, but the response will be somewhat conditioned by the fact that children's mental health beds are at no cost to the children's aid society. Therefore, if the clinical needs are such, they would likely first make a referral to the children's mental health system.

What you are probably implying is the need to look at the issue of demand in terms of the mental health sector and whether this is a release mechanism from that sector. That is quite a legitimate question. We have some information provided by the Ontario association.

11:10

Mr. R. F. Johnston: The referral process here is crucial. The other statistic that is not here that would be interesting would be the waiting lists for residential care, both the boarding homes and the children's mental health centres. I forget what it is at now, but for children's mental health it used to be around 2,000, as I recall the figure for Ontario. It would be interesting to see where that stands, and we might get a better idea of where the for-profit sector is fitting into that in terms of care of people because of the referral process and the waiting list problem with the children's mental health centres.

Miss Stephenson: Are you suggesting that the professionals who make the assessment and determine the placement of children in these circumstances through the children's aid societies might refer children with very severe mental health problems to a children's boarding home in which the primary clientele is relatively within the range of normal--whatever the hell normal is, because I do not know--and that this is something that is happening with frequency?

Mr. R. F. Johnston: I just do not know. That is the problem. There are two things. One would be that there is a financial incentive for a children's aid societies to refer a child to a children's mental health centre because it does not come out of its budget, whereas it costs the CAS money to send a child to the boarding home. That is an incentive to go the other direction.

My information is that there is an increasingly large number of kids in the boarding home sector who have large mental health needs, and that is not what the boarding homes were initially established for. I am not sure we are necessarily getting the right type of service, although as Mr. Duda has said, that can be purchased for children's mental health centres through their day programs provided to the kids in the boarding homes.

Miss Stephenson: It is; with great frequency, as a matter of fact.

Mr. Duda: The other factor we considered is that for \$60 or \$80, the operators would likely not accept individuals who have active psychoses or who are highly disruptive, because they cannot provide even containment in supervision, let alone any clinical services, for that rate.

Mr. R. F. Johnston: That raises the other whole issue about who is on the waiting lists. In some cases, children's mental health centres have shown some reluctance to take some of those harder-to-serve kids as well. Where are they ending up if they are not in either of those places?

Miss Stephenson: In certain other children's mental health centres that have the capacity to deal with them.

Mr. R. F. Johnston: But there is such a long waiting list.

Miss Stephenson: It would be useful to know what the waiting list is at this point.

Mr. Chairman: Any further questions on these particular sections?

Mr. R. F. Johnston: I have many others, but that is all I had on the boarding homes.

Mr. Chairman: Go ahead.

Mr. R. F. Johnston: You said you are getting the foster care rates for us at this point.

Mr. Duda: Yes.

Mr. R. F. Johnston: I once did a comparison, which I have never had contradicted by the ministry, of the amount of money given to a family benefits mother to stay home with her three children, say in the 10-year-old to 13-year-old range or something like that, as compared to the amount of money we would give to a foster parent to look after the same three kids.

When I worked it out a year and a half ago or so, the family benefits mother received about \$400 less to have her kids stay with her in her own home than foster parents would receive to look after those kids if they were taken from her for some reason, for protective reasons or whatever, and turned over to them. I wonder whether that discrepancy is still there and whether we can get some figures comparing that sort of thing.

Mr. Duda: Yes. For example, if a sole-support mother had one child and then there was an additional child, there would be an increase in the rate. One could look at the marginal increase to see what money had been provided for the additional child. Having said that, though, in the basic rate, consideration is given to shelter. The marginal rate would be for those costs associated with an additional child, such as food and clothing. Part of it would be hidden, so to speak, in the original rate.

We can provide some basis of comparison. You are no doubt correct that the rate paid to foster homes is greater than the marginal rate for an additional dependant on family benefits.

Mr. R. F. Johnston: The number of foster care placements--it is in the estimates book for this year--is still increasing but the rate seems to have slowed somewhat. Am I right or wrong about that?

Mr. Duda: The number of foster home beds?

Mr. R. F. Johnston: Yes.

Mr. Duda: I think that provided us approximately 5,000 foster home beds. From my discussions with children's aid societies, there are some difficulties in the foster home system. First, there is the shrinking number of families who are willing to provide foster home services, which is probably a function of two working parents. Second, there are housing issues related to potential foster care providers. Third, there are the needs of the individual child.

Societies are many times dealing with individuals, adolescents particularly, who cannot be accommodated or at least cannot best be accommodated in a foster home or, if they can be, they need a very special family to deal with that issue. We are looking at ways of recruiting foster parents who do have those special qualities and can deal with the more difficult youngsters.

Mr. Chairman: As a supplementary to that point, do you have any statistics that would show the upping of the age of young offenders has had some bearing on the foster home situation? Some of these people may be going to what would be Young Offender Act homes, whereas before they probably would have gone into foster homes.

Mr. Duda: We can give you the data in terms of the number of youngsters less than 16 years of age who are now in open custody. For want of a better definition, open custody means a group home. That has increased significantly. We can get you those data.

Mr. Chairman: What I am getting at is, has that reduced the number of children going into foster homes?

Mr. Duda: I do not think so.

Mr. R. F. Johnston: I may be wrong, but I think you would find that the number of correctional kids going into foster homes would not have been that high in the past either.

Mr. Chairman: Is that right? Where did they go?

Mr. R. F. Johnston: Detention homes, group homes, I guess.

Mr. Duda: Their needs might have been defined as child welfare needs, and they might have found themselves in a boarding home purchased by the CAS.

Mr. Chairman: Okay. I am sorry; I did not mean to interrupt.

Mr. R. F. Johnston: That does raise a question, though, which it strikes me the committee needs to think about at some point. We have thought about this in terms of the Ministries of Community and Social Services and Health, but because of what we have done with YOA in Ontario, splitting it between the two ministries, we have some social policy questions around profit and nonprofit which affect the whole question of group homes and other options for 16-year-olds to 18-year-olds in the province that are not handled by this ministry.

At some point, if we want to get involved with the question of how we are dealing with correctional kids, we might want to look at the statistics from the other ministry. My information is that the use of for-profit agencies under the Ministry of Correctional Services is more extensive than it is under the Ministry of Community and Social Services. That raises some very interesting policy questions.

Mr. Baetz: I have a supplementary, still on foster parents.

At one time, the philosophy or the policy governing assistance to foster parents was based on the fact that a foster parent is a very generous, community-minded person who is prepared to take in children out of the goodness of his or her heart or that of the family and that the financial support he or she would get from the CAS or anybody else is just sort of an add-on. What is the philosophy today? Do you still regard the parents as providing a service to the community, or are you looking at foster parents more as a resource and almost as a for-profit or at least break-even service?

Mr. Duda: We see them basically as volunteering their time. The expenses associated with the child, namely, food, clothing and out-of-pocket

expenses, would be offset by the rate paid by the CAS. We have approached it that way. Other than some significant systems of special-needs foster parents, we are dealing with children who may have been in a children's mental health centre. In fact, some children in health centres have therapeutic foster parents who work in concert with a professional.

11:20

For the most part, we see them as volunteers who volunteer their time--committed, altruistic individuals. They are special families that provide a service and get some small compensation to offset their out-of-pocket expenses. It takes the commitment of the societies, creative recruiting and committed staff to give foster parents support to continue in that role.

Mr. Baetz: Which makes it even more perplexing. Going back to Mr. Johnston's study of some years ago, you say family benefits allowances are much lower than the allowances to foster parents. Anyway, the philosophy continues essentially the same, although there has been perhaps more thought given to paying a little for the time they put in.

Mr. R. F. Johnston: My other questions fall in the next sections. I did not have anything on attendant care. You do have a group homes contract under the Young Offenders Act, primarily the boarding homes?

Mr. Duda: Yes.

Mr. R. F. Johnston: The information I asked for about private ownership of that should be covered there?

Mr. Duda: Yes. It will be.

Mr. R. F. Johnston: Is it under a later section that we deal with group homes in generic terms under the CAS protective question? How do we find out which of those are privately owned and part of chains?

Mr. Duda: We have provided information on only the for-profit homes but, if you want, we can provide the capacity in the whole system and then separate out the for-profit ones. For example, we have beds in children's mental health facilities that are not for-profit. We have a great number of beds in children's aid societies, children's institutions, that are not for-profit. We can give you the capacity there and provide a contrast against the for-profit, including a list of the profit-making agencies, including the chains.

Mr. R. F. Johnston: It might be useful in that it would be similar information to what we were getting from the Ministry of Health. It would allow us to have that kind of comparison.

On the approved home program for the developmentally handicapped, there are 71 clients and 40 approved homes. Have those figures been going up and down?

Mr. Duda: With the introduction of community services over the past 12 years, it has gone down significantly. It was more or less the only community placement that facilities used in the late 1960s and early 1970s; obviously, there are others now.

Mr. R. F. Johnston: Are these very old clients now? Do we know?

Mr. Duda: From what I understand, there tend to be higher-functioning adults living in these settings. I will ask Ms. McCartney whether that is correct.

Ms. McCartney: I think they would probably be--

Mr. Chairman: If you are going to answer questions, you will have to be up here, just to get on Hansard. I am sorry about that.

Ms. McCartney: We assume there is a middle-aged to ageing client group in the approved home program. For younger clients, we are more apt to put them in programs such as the supported independent living program, which is an apartment program, or in group homes.

Mr. R. F. Johnston: Is there any attempt to move these 71 clients into that kind of situation, or are they being left there?

Ms. McCartney: Some of the clients in these homes have been moved to alternative residential settings that are considered more appropriate for their needs. In addition, we have converted some of the approved homes into family home programs. That process is continuing on an ongoing basis.

Mr. R. F. Johnston: Under the community services division, support services for the developmentally handicapped, you indicated that the purchase of psychological assessments on behalf of developmentally handicapped people and transportation for developmentally handicapped people is primarily handled by for-profit agencies. Do we have an idea of where that is taking place and by whom? I am thinking that in some areas it is the public institution--Cedar Springs or somebody like that--that often operates these kinds of programs and therefore it is not done for profit. Can you give us a regional breakdown of where that takes place outside the public sector?

Mr. Duda: Yes. We will attempt to do that. From my understanding, it is a modest amount. For example, a group home that may require an assessment for a client may use a community psychologist and pay him so much, a few hundred dollars, for that assessment. The bulk of the money spent in purchasing assessment in the residential and nonresidential settings is for the services themselves, directly provided by the agencies. We will attempt to get you a breakdown.

Mr. R. F. Johnston: That is good. The family home program is the more recent program; it has been developed in the past few years. Is that right?

Mr. Duda: Yes.

Mr. R. F. Johnston: At one stage it was beginning to sound as if this was going to be a policy emphasis by the ministry as an option to look at, partially because of cost and developing a family kind of framework for people. I am surprised that there are only 136 clients using this. What has been the pattern of growth there?

Mr. Duda: Maybe I will ask Jean to comment. I think it is partly a function of the level of the need of clients. Over the past five years, we have closed a number of beds in mentally retarded facilities. Those individuals being placed in the community had needs that could be accommodated only in more supportive and professionally managed settings. Obviously, for a member of a family who is severely handicapped, a family home would be the

most appropriate. That would be one factor; there may be others. One is that it is new.

Mr. R. F. Johnston: I do not need it right at the moment, but I would not mind a bit of an analysis of what has taken place, how many attempts there were to make these placements, how many failed and whether the reasons were excessive handicap or whatever.

You have 16 family home agencies participating. Can you give us an idea of where these are regionally and the rates? At the moment, I have forgotten the rate. Is it \$21?

Mr. Duda: We pay the host family \$18 through the agency, and the remainder is made up from the guaranteed annual income system allowance. The individual pays and retains a comfort allowance.

Mr. R. F. Johnston: I noted that when you were talking about this, you were putting some of these people in a for-profit category according to your definition at the beginning. Am I wrong?

Mr. Duda: Because the agencies themselves are not for profit, but they then turn to individual families, the rate is significantly higher than the foster care rate. Therefore, the criterion we use is that they are not volunteering their time. There is some compensation for the time spent, and we consider that for purposes of this discussion to be in the for-profit category. Arguably, they could be in the other, given the \$18 per diem.

Mr. R. F. Johnston: Exactly. What you were suggesting earlier is very important, that we understand the standards and so on for these various programs, and I was wondering whether you could do a comparison between some of these, the expectations of foster parents versus the expectations of families who undertake this kind of program and the rationale for the rates. We should be able to get that by going through those documents.

Mr. Duda: Yes.

Miss Stephenson: May I ask where there is a client need definition that relates to each of these placements that is defined?

Mr. Duda: In terms of the criteria for using the programs?

Miss Stephenson: Yes. Is it easily defined or is it in the usual sociological jargon somewhat unintelligible to those of us who are not social service workers?

Mr. Duda: The guidelines of the family home program are fairly clear.

Miss Stephenson: Are they?

Mr. Duda: Yes.

Miss Stephenson: It would be useful to have those sets of guidelines in each of the categories.

11:30

Mr. Duda: What will not be too clear to provide, or what we will not be able to provide, is information on the use of foster homes. We can give you

a general idea. Some societies have been very creative in using foster homes for children who have complicated needs. Other societies have used them for developmentally handicapped children. The bulk of them obviously are children who require homes and parents in a supportive environment. We do not have criteria. Those criteria are available from individual children's aid societies. For the family homes, we have the guidelines.

Miss Stephenson: Children's aid societies vary as much as school boards do, if not more.

Mr. R. F. Johnston: On the group homes for the developmentally handicapped, where you say there are profit and nonprofit, is it possible to get us the profit-makers there?

Mr. Duda: I will get the names of the organizations. We have the locations, but we can get the names of the organizations as well.

Mr. R. F. Johnston: It would be good to know which are involved. Is phase 2 of the special needs program under review? Are we going to get an announcement, or did I miss one, about the changes in rates, etc., for the home support program under special needs?

Mr. Duda: Phase 2 of the special services at home program has been a popular, well-utilized program. As I mentioned, it provides services to families caring for their children. In the weeks ahead, we will have an announcement around some expansionary funding of that program. In the longer term, we have to look at the usefulness or utility of applying that approach to other than children. As you know, now it is only applied to children when they are with their families. As those children become adults, they are still with their families, and those same resources may need to be applied.

We are also hearing from individuals or organizations that provide services to the physically handicapped. They see this program as a very viable way to keep families intact and to reduce their need to use residential services.

In the weeks ahead, there will be some announcement around expansion. In the longer term, we have to look at this way of providing service as an integral component of our service system for the handicapped.

Mr. R. F. Johnston: I think the committee might be interested in that. I had not realized the problems, for instance, for the visually handicapped in making use of this kind of program in an effective way until Mr. Cooke invited me to Windsor to meet some people who had problems. The expansion of this kind of program would be very interesting in terms of the range of profit and nonprofit programs that are out there.

How easy is it going to be for us to glean from the manual in this case--because I got quite confused by the way this operates--how they determine how much money you can get? There are all sorts of things said about if you have a child who is being deinstitutionalized, you can get up to \$10,000, or whatever the figure is. If your child has not been institutionalized, even if he has severe needs, you may get only \$4,000 or whatever. Can we have that broken down? How that has operated has always confused me. Can we also hear about where the money goes? As you say, a lot of the people are private psychologists and others who actually provide the stimulation for these people.

Mr. Chairman: Did you have that book in advance, Mr. Johnston?

Mr. R. F. Johnston: I have been the critic since 1981.

Mr. Chairman: I see. All right.

Mr. R. F. Johnston: I was with a group that got funded by the ministry once, but that was all.

Miss Stephenson: It is a long history.

Mr. R. F. Johnston: Time for a change. If I could just move to triministry, I notice only 850 people are sharing in these contracts. That is a small portion of the developmentally handicapped in the homes for special care. Can you provide us with some updated regional information about individualized program and about where services are being provided and where they are not? You mentioned a few nursing homes have actually taken on the job themselves rather than contracting it out to a local service agency. Can we have those names? It would also be interesting to get an update on triministry.

I can leave the other question I have, because I notice there is a reference to Para-Med and some other groups and the use of those kinds of organizations. Home support delivery is something I would like to raise, but we can deal with that under family support and other groups.

Mr. Chairman: Are there any further questions from members of the committee?

Mr. Sargent: Are we as far as halfway houses yet?

Mr. Chairman: No. We have got as far as, or are just coming up to, elderly services.

Mr. Sargent: Elderly services.

Mr. Andrewes: You have been through that.

Mr. Sargent: You go to hell.

Mr. Chairman: That is going to be of particular interest to those of us who are 49 and older, which probably includes all of us.

Mr. Andrewes: I have two short questions. With respect to group homes for the mentally handicapped, the local associations have had mixed success in establishing them in various jurisdictions. Some communities are much more receptive than others. Some are quite prepared to enter into the zoning arrangements quickly, while others are a little more hesitant.

Is there a policy direction with respect to providing spaces in group homes as they become available to individuals who are resident in the community the group home serves? Do the residents of the community in which the group home is located have preference over those from other communities?

Mr. Duda: I do not think we have an explicit policy. During the period of depopulating facilities, we applied a rule that we wanted to give some priority to individuals who would be returning to the communities from large facilities. Having said that, local associations place a high priority on servicing their own residents, and the likelihood is that the residents who

receive service in any one group home do originate from that community. It is our broad objective to repatriate individuals from facilities to their home communities. Agency discretion is mentioned. I think the associations would be biased in terms of servicing individuals from their community.

Mr. Andrewes: Then it is primarily left up to the local agency?

Mr. Duda: Yes.

Mr. Andrewes: In the light of the fact that some agencies have had greater success than others in establishing group homes, my concern is that certain communities may not be able to provide that service as readily as other communities. I wondered whether there might be some overall policy direction to assist local associations in dealing with the powers that be in the communities.

Mr. Duda: I do not know whether it is a policy. We do have a practice of providing support to our area offices and individual program supervisors of local associations to assist them in dealing with any community resistance, whether it be prohibitive zoning bylaws or individual neighbourhoods feel the introduction of a group home would be disruptive.

As you probably know, that has had mixed success. Sometimes a careful introduction of the group home and discussions in a community neighbourhood meet with considerable success. In other cases, that same approach in another community just exacerbates the opposition. Other than the help we give to our area offices, that would be an indication of our policy, more by practice than by anything written.

Mr. Andrewes: The other question I have relates to the vocational rehabilitation services and the movement away from providing services for children and those services being assumed by the Ministry of Education under Bill 82. You mentioned that some of these services have been purchased by the ministry out of the province. I assume that the services were not available in the province. Are you confident that the Ministry of Education and the local boards of education will be able to provide those services in the province, or will they continue the policy of purchasing the services somewhere else?

11:40 a.m.

Mr. Duda: A number of children are currently being serviced in schools purchased by the Ministry of Community and Social Services. We continued that practice, beyond the introduction of Bill 82, as an interim procedure for a year. We expect the Ministry of Education and local boards will arrange the ways and means of accommodating children's individual needs.

In answer to your other question on quality, the fact that we provide services to the learning disabled is rooted in our 10-year history as a function of an appeal of the Social Assistance Review Board at the Supreme Court level that obliged us to provide that. As a result, we provided that service. I might add that the service selected was at the discretion of the parent and according to the individual needs of the child.

In our response, we had limited accountability as a function of the Supreme Court decision, not necessarily what we might want to do. Having said that, it would be very difficult to hold a school accountable in Minnesota, Connecticut or Manitoba.

Mr. Baetz: I have a general question not related to this.

Mr. Chairman: I believe Mr. Andrewes has finished, but before you ask that question, I notice Dr. Fraser Mustard is coming in at two o'clock. We do have a few further items to deal with. If there are as many questions surrounding that as there were with this, we may never get to Dr. Mustard.

Until what time do you want to sit? Until what time did you sit yesterday? Was it until 1 p.m. or until noon, and then back at two? It was noon.

Unless it is a burning question, Mr. Baetz, perhaps we could move on.

Mr. Baetz: It is a general question covering the total program. He can answer it in one minute, if he has the answer.

Mr. D. S. Cooke: Can you put it in one minute?

Miss Stephenson: It is unlikely.

Mr. Chairman: If we keep interjecting, it will take longer than that just to get you to start. Go ahead.

Mr. D. S. Cooke: He is going to tell us that we cannot always compare apples with apples.

Mr. Baetz: No, I am not.

From the overall perspective of the ministry and all the services it provides, directly and indirectly, do you see a trend towards more services going to organizations operated for profit? As more specialization takes place, do you see the establishment of smaller for-profit groups providing highly specialized professional services, or are these services now under the administrations of the agencies you are working with?

Mr. Duda: If I had to guess at a trend, I would say it would be more towards nonprofit organizations. I say that because we will probably need to expand services for the developmentally handicapped, which are predominantly serviced through the nonprofit sector, as well as other services for the physically handicapped.

From a quick calculation, I believe our expenditures in the nonprofit sector are approaching 97 to 98 per cent; those in the for-profit sector are two to 2.5 per cent.

Mr. Baetz: But is the trend towards more nonprofit involvement?

Mr. Duda: Yes.

Mr. Chairman: Does that answer it? I wonder if we can move on to elderly services.

Mr. Duda: I will be concerned with the whole spectrum of our services for the elderly, because I believe you requested it, probably because of Ministry of Health services, particularly nursing homes that provide a similar service, namely, extended care.

Given the shortage of time, I believe we should spend most of our efforts, at least this morning, on the municipal and charitable homes for the

aged. However, I will quickly go over the first three, especially the second one, homemaker and nurses services, because I think that is germane to your deliberations.

First, the elderly persons' centres are all nonprofit. They are recreational and social programming in orientation. They are found throughout the province. There are 170 of them, most in the larger urban centres. We have a modest amount of funding available, with a ceiling of \$15,000 per centre. In addition to that, these centres can apply for home support funding, which is another source of funding.

Second, and this may be of some importance, is homemaker and nurses services. There are two ways to provide homemaking services through the Ministry of Community and Social Services. The bulk of them are provided through municipalities, which then purchase services on behalf of individuals on a needs-tested basis. We share the cost 80-20. Additional to that is the introduction of the new integrated homemaker program, which is 100 per cent funded by the ministry and delivered through the home care unit, which is a Ministry of Health entity. In both cases, and I am sure the Minister of Health indicated this, homemaking services can be provided by both the for-profit and nonprofit sectors.

Mr. D. S. Cooke: Can you tell us which municipalities have contracts with the for-profit sector and which are with nonprofit?

Mr. Duda: I do not have it here, but maybe I can flip ahead a few sheets and give you an idea of the dimensions of the for-profit and nonprofit in terms of hours of service and costs. There is a typographical error in the information provided. The dollar sign should be blotted out on the hours of service. Obviously, that should be reflected in numbers, not dollar signs.

Interjection.

Mr. Duda: It is in the attachment.

Mr. Chairman: Is that in the new material?

Interjection: It is in a supplementary sheet.

Mr. Chairman: Which sheet is that?

Mr. Duda: It says "service statistics."

Mr. Chairman: Do they all go behind that tab thing?

Mr. Duda: Yes.

Mr. Chairman: Everything we have left, other than those first two pages, goes behind this service tab.

Miss Stephenson: No, there is the day care one.

Mr. Duda: There is a day care one as well.

Mr. Chairman: All right.

Mr. Duda: The hours of services provided by homemaker and nurses services in the for-profit sector is 175,000 hours; in the nonprofit sector,

1,900,000. In terms of the cost, because these are run from municipalities and we contribute significantly, it is \$1 million as opposed to \$11 million. You are looking at eight or nine per cent through the for-profit sector. The last line just shows you our contribution in terms of the cost to the province of those services.

One reason for-profit is selected is that they are less expensive, and they are less expensive because in some cases they are more efficient. They will provide services in a more flexible manner. At one time, nonprofit homemaking agencies, or a lot of them, would only provide services in a block of four hours, and the individual might require only two hours. The other reason is possibly the overhead; they are more efficient and have less overhead. At other times we use them when the service is not available from the nonprofit sector. We can get you a breakdown, which may take some time because this is at the municipal level.

Mr. D. S. Cooke: We are going to be meeting for a while, but if we have to collect it from the municipalities, maybe when you are getting that it would be interesting to attach the wage rates to each of them. I think that in some of them what you might describe as more efficient also relates to lower wages, which is not necessarily more efficiency.

Mr. Duda: No, I would not consider it that. However, my understanding is that the rate paid to homemakers individually is low. It is the minimum wage; so the cost differential is not necessarily a function of different wages.

Mr. D. S. Cooke: The difference would be that Red Cross, for example, which supplies a fair amount of homemaker services, pays about \$6.50 or six bucks per hour or a little less. The private ones pay a buck less. They pay right at the minimum wage.

Mr. Duda: We can get you that information.

Mr. R. F. Johnston: The Red Cross is under a fair amount of pressure now from the private sector, at least according to the letters they send me.

Mr. Duda: Yes.

11:50

Mr. Chairman: Will you continue, Mr. Duda?

Mr. Duda: The next one is home support services, which include Meals on Wheels, friendly visiting, day programs for the elderly, security checks and escorted transportation. This is provided entirely through the not-for-profit sector.

I think the next one is the most significant program--I am not sure we can cover it in 11 minutes, but I will attempt to--the municipal and charitable homes for the aged.

Mr. Chairman: Can I go back to that, if you do not mind? I got this information about Meals on Wheels gratuitously, but apparently it put in a budget and it had \$5,000 left over at the end of the year. It asked, "What do we do with it?" They said, "Keep it," and they gave it its budget over again. I know that is not for profit per se, but it seems to me that if you have \$5,000 left over and you get the same amount you got the year before, the organization is clearing a profit. Is it that closely watched?

Miss Stephenson: Meals on Wheels has real difficulty--not difficulty, but it sure works hard to make sure its budget matches what it can provide or what it can--

Mr. Chairman: Yes. When it had \$5,000 left over and it tried to--

Miss Stephenson: This is Brampton?

Mr. Chairman: I will not tell you who it is. I do not want to get the person in trouble, but--

Mr. Duda: I do not know the individual situation, but perhaps I can give you the reason contributing to that. Up until this year, we have provided only 50 per cent of the financing. Communities found it very difficult to raise the other 50 per cent, particularly those communities that did not have large United Appeals or municipalities that wanted to participate voluntarily. Based on what you have told me, I would just assume that the \$5,000 was allowed to be kept as a surplus and applied in the next year towards its 50 per cent, given the history and the difficulty of delivering this service when the only financing is at 50 per cent.

This year we are raising it to 60 per cent and next year to 70 per cent for that very reason. The majority of the service tends to be in larger urban centres and it is a function of the funding arrangements. Strategically, we wanted to provide services more evenly throughout Ontario and obviously more adequately in rural communities. That may be the reason contributing to that.

Mr. Chairman: Okay. I am sorry to interject.

Mr. Duda: Homes for the aged have a long history with the Ministry of Community and Social Services. They provided services prior to the introduction of extended care. In fact, some of them started as poor houses. Prior to the introduction of extended care, every individual in the facility was obliged to pay according to his means. In other words, they were needs-tested and they were provided services, partially or fully subsidized in so far as they could not pay.

With the introduction of extended care, we then had a different funding mechanism. The Ministry of Health introduced one and a half hours as a prerequisite for care. We then applied that same prerequisite, and for those individuals who have personal or nursing services over one and a half hours, we consider those as extended care clients within the capacity of our bed requirements.

Those individuals who have less than an hour and a half of care are considered as receiving residential services and they continue to be needs-tested. In other words, an older person would be obliged to pay up to the full cost of care assuming that, at a minimum, each individual would have left over at least a comfort allowance.

The per diems are different from nursing homes. That is an important consideration. Theoretically, while we provide the same level of resources for extended care to both charitable homes for the aged and municipal homes for the aged, their effective per diems are higher. There are a number of reasons for it.

First, the history of the homes for the aged is to provide services to individuals, regardless of their need. That is their legacy. Prior to 1972,

they kept people regardless. As a result of that legacy, our municipal homes for the aged legislation is open-ended. In other words, we fund the cost of the service on a 70-30 per cent basis. While they may start off with an artificial per diem, which is \$2 less than the extended care rate, at the end of the year when you look at their expenditures measured against the days of care, their average per diems are closer to a \$70 average rather than to the extended care rate, which I understand is somewhere around \$48 or \$46. Actually, somewhere around that sounds rather precise for an estimate.

There are reasons contributing to that. One is the level of care required by the individuals, given the open-ended nature of funding and the mandate of the homes to provide services regardless of need. Second, they do in many cases provide a very full range of social services, recreational services and adjutancy services. Third, in some cases their administrative costs are possibly higher than those of nursing homes.

In the charitable sector they have tended to provide predominantly residential care. That is the needs-tested, nonextended care sector. When they provide extended care, their average is around \$60. I should qualify that, because it is a distorted average because of two large homes, namely, Baycrest and Providence Villa, which I believe have per diems of around \$90 to \$95. If you take them out of the average and recalculate it, our cost for charitable homes for the aged is a few dollars higher than the extended care rate, possibly around \$50.

I know it is a little complicated, but by way of summary, in municipal homes for the aged it is open-ended. As a result, they have the capacity to provide service as long as it is required and appropriate, regardless of the level. The charitable homes have a fixed per diem, the same as extended care, but because we pick up 50 per cent of their deficit, in some cases 70 per cent--for Providence Villa and Baycrest it is 70 per cent of their deficit; we have done that historically; although it is not a function of the law, it is a practice--their per diems are in the low \$60 range as opposed to \$48. However, once you take out the large facilities that have a very full range of services--in many cases they might be seen as flagship facilities--the average is approximately \$50 or \$51 per day.

The municipal homes for the aged have satellite services, and that is where they may engage for-profit operators. In other words, they are allowed by law to purchase service from other providers. Charitable institutions are not.

I will go to this before I go to the number of satellite beds. By way of summary, we have 95 charitable homes and 90 municipal homes. In the charitable sector, an overwhelming number, 6,600, are residential beds and 3,400 are extended care. In the municipal sector, the residential capacity is 7,136, and there are nearly 11,000 in extended care. The total number of beds in the municipal sector is 18,000. In addition to that, the aforementioned satellite beds number 799, giving us a grand total in both sectors of 29,000 beds, 10,000 in the charitable sector and nearly 19,000 in the municipal sector.

Mr. D. S. Cooke: How many of those satellite beds will actually be for profit?

Miss Stephenson: It is on the next page.

Mr. Duda: The majority. It is on the next page.

Mr. D. S. Cooke: Sorry.

Mr. Duda: As you will see there, out of the 52 operators, 45 operators are for-profit and seven are nonprofit. The numbers of residents are 573 and 226 in the not-for-profit. I might say that the word "satellite" implies small. There are some, particularly in the not-for-profit--obviously, some of those seven--that have to be rather large. They are larger than what you might typically consider a satellite home. The majority of the for-profit beds, as mentioned here, are smaller ones with three to four beds.

Mr. D. S. Cooke: Would those be the type of homes where the husband and wife do what is necessary to the house and bring in a few people? I have seen some of those satellites in the Niagara area.

12:00

Mr. Duda: Yes, it includes that, but I think we should try for a breakdown of the settings, because some of them would likely be purchased from people operating rest homes. There would be a few beds in a rest home setting or similar to a rest home setting. Some of them are not as small as family-type facilities. It would be much like a residential facility in a home for the aged with 24-hour staffing and the like. I would not consider the ones in Niagara for-profit.

Mr. D. S. Cooke: It is more like foster care.

Mr. Duda: If we began applying our earlier definition, there would be more than out-of-pocket expenses. Theoretically, one can consider them for-profit. None of our homes purchases management services from for-profit agencies, but from time to time, many of them purchase dietary and food services and contract out part of their business: building maintenance, housekeeping or payroll. They feel that is cost-effective, but none is run by a management company.

I still have child care, which is a significant service that utilizes for-profit.

Mr. D. S. Cooke: Could we get a breakdown of the satellite homes to find out which they are and who owns them?

Mr. Duda: Yes, we will get a list of satellite homes. Child care historically involves day care, but latterly a more appropriate name is child care. The ministry has two basic functions in child care: licensing all day care centres, whether or not there are any funds provided, and providing funds through municipalities and approved corporations to provide subsidies to families that cannot pay for the cost of care. The notes give the historical development from 1946 to the present pertaining to the role of the Ministry of Community and Social Services.

Services are not provided directly by the ministry, but predominantly through municipalities. Approved programs which are run through agencies and not municipalities are funded to provide services for handicapped children. There is a handful, a small number, of approved corporations--churches and incorporated nonprofit agencies--that we fund directly rather than through municipalities.

Mr. Sargent: Can they be for-profit?

Mr. Duda: They can be, and I can get a list of them. I do not think we directly fund any for-profit operators. The for-profit operators that are funded with subsidies are funded indirectly through the municipalities. We have some statistics on the number of facilities and the capacity of operators. I have underlined those that are for-profit. This is lifted from our day nurseries information system. The total capacity of 79,000 is broken down and the 2,000 centres are broken down, as you see displayed in your book and on the transparency.

The approved charitable corporations--those few that are approved under the act to provide services--have a capacity of 4,000 of the 79,000. There are a little under 1,000 approved charitable corporations that provide services to the handicapped. There are 25,700 charitable corporations that are not approved to provide under the act but have licensed spaces. I should elaborate that we do not fund them directly. They are likely to be recipients of funding from the municipality. Because they are licensed, we know the status of their incorporation.

Mr. Chairman: Has the number of the private individuals gone up over the period that the various increases of subsidization have gone up?

Mr. Duda: I am not in a position to answer that.

Mr. Chairman: Can you provide us with that information?

Mr. Duda: Yes.

Mr. Sargent: What is the thinking behind the fact you do not fund them? The municipality does not have funding for that.

Mr. Duda: We provide 80 per cent of the funding for municipalities. They have the discretion to decide whether they want to participate in the program. When they do, they decide on their level of participation.

When they make requests for funds, we respond within our capacity to fund them. When they spend the money, we reimburse them 80 per cent. Because of municipal discretion, the majority of day care funds is spent in four municipalities: Metropolitan Toronto, Hamilton, Peel and Ottawa. It is obviously an issue, possibly not subject matter for this committee, but I believe for further consideration of the direction the government may want to take in terms of day care.

We have licensed for-profit organizations that provide services, individuals representing unincorporated groups, and municipal corporations that directly operate and run their day care centres, totalling 8,000. There are 20,700 noncharitable corporations. As for private individuals, which might be families operating small day care centres in their homes, there are nearly 15,000.

Given the nature of your other requests, you would probably like a breakdown of the noncharitable corporations in particular, because there are 21,000 spaces there. This is the capacity, the number of spaces, whether they are funded or not. The funding of day care, as I mentioned, is through the municipality, and the \$108 million provided for subsidies is directed to both the for-profit and nonprofit sectors.

Although we do not have them here, I believe the percentages of dollars directed to for-profit and nonprofit organizations would be useful for your

consideration and deliberation. From memory, it is approximately 35 per cent. You are looking at \$35 million to \$40 million out of the \$108 million. I will get more precise figures on that and provide them to the committee.

Mr. D. S. Cooke: Are the staffing requirements of municipal day care centres different from those of private ones?

Mr. Duda: No. The staffing requirements are quite explicit in the day nursery standards, which are part of the regulations of the Day Nurseries Act. They are inspected by our early childhood education consultant and are expected to meet the same standards. However, I would guess that some municipalities may want to staff above and beyond those standards.

Mr. D. S. Cooke: I thought the number of early childhood education graduates required in municipal centres was different from that required in for-profit private centres.

Mr. Duda: It may be at the discretion of the municipality that it wants high-level training for its staff. It is not a function of our law.

Mr. D. S. Cooke: The person I talked to was the Ministry of Community and Social Services inspector in our area, but perhaps the Windsor staff is at a higher level. My impression, however, was that it did not require as many certified employees as the municipality does.

Mr. Duda: We obviously have a difference. I could doublecheck. It is important that we clarify that.

Mr. Sargent: Did you say that the majority of day care funding went in capital grants to Metro Toronto markets, more so than to outlying parts?

Mr. Duda: Yes. I believe there are a number of factors. First, the basic nature of the program is discretionary. Municipalities have to want to participate. Two things condition their responses: they must be philosophically predisposed to providing the services and have the financial capacity to do so. They must treat it as a priority and fund it.

Mr. Sargent: Why would Windsor and Owen Sound not get their share on a pro rata basis?

Mr. D. S. Cooke: They have to lay out local cash.

Mr. Sargent: Does the municipality have to match it?

Mr. Duda: It is 80-20. It has to provide 20 per cent.

The average cost is about \$4,000; the cost of one space to the municipality is approximately \$800. It depends on the age of the child; it may be after-school care or a few hours in the afternoon, perhaps at lunchtime. Infant care can be quite expensive, because you have high staff ratios. Toddlers are less. It is a significant cost to the municipality, however.

12:10

Miss Stephenson: In those regulations, the staffing requirements are precisely the same for all centres providing day care, depending on the age group it caters to.

Mr. Duda: Yes.

Mr. Baetz: All income tests--

Mr. Duda: Anyone who receives a subsidy has to be needs-tested and he or she has to qualify. There is municipal discretion in the application of the needs test, because there are some elements in it such as shelter and the level of indebtedness and also a category--I forget the technical name--that is just written off in terms of allowing some discretion in the income.

As a result, you can have some municipalities offering services only to individuals with gross family incomes of less than \$15,000, whereas in Metro Toronto it may be well into the \$20,000 to \$24,000 range. There are two levels of discretion: whether they want to participate in a program and whom they want to treat as a priority within the needs-testing system. Most municipalities have sole-support and single parents as a priority.

Miss Stephenson: The discretion is usually applied reasonably in most instances, but as I recall it, there was a problem several years ago with a municipality whose discretion was rather more extravagant. I was going to use the word "liberal" but I was not sure that was the right definition. I understand there were instances in which the total family income of approximately \$50,000 was being used as the limit beyond which subsidization would not occur.

Mr. Duda: You are probably referring to the notion of indirect subsidy. Many municipalities provide indirect subsidies to families, regardless of their level of income, by a charge-out rate, a price that is less than the real or effective per diem, and then the costs are borne through the subsidy process.

Miss Stephenson: Right.

Mr. Duda: In principle, it is in violation of the Canada assistance plan. We have attempted to correct that, with great difficulty, because in some cases the cost to the full-fee-paying parent would have to go up significantly. It has been implemented over a number of years. In fact, right now we are again reviewing that policy in the context of longer-range objectives in the child care program. That is probably the instance you have remembered.

Mr. D. S. Cooke: Do you have any information on ownership in the private sector--we do not need it right now--but especially the large companies and maybe even, if possible, on a regional basis?

Mr. Duda: There are 20,000 spaces in the noncharitable corporations and another 3,000--we have 37,000 spaces, so it will be a fairly significant list. It will be a printout from a computer, and maybe for the committee's purposes, we could highlight--

Miss Stephenson: You will have to supply magnifying glasses.

Mr. Duda: You can have that list, but you also might want to look at those operators that are chains. Many of the day care operators that are for-profit are small settings. They might run two, but likely one, and feel they would rather work for themselves than for others.

Mr. Sargent: Are there chains in this field too?

Mr. Duda: Kinder-Care is the most significant one.

Mr. R. F. Johnston: We should get that breakdown.

Mr. D. S. Cooke: Yes. I do not want all the tiny ones, but the big chains would be important. Also, for example, I do not think we have any of the large chains that go across the province in my area, but we have one private day care company that owns a whole bunch and it corners the market. That kind of thing on a regional basis would be important, but I do not want to know about the local day care centre that has 20 kids or whatever and that is the only one it owns.

Miss Stephenson: Are you talking about a local chain?

Mr. D. S. Cooke: I am saying province-wide is important, but it would be nice to see who corners the market in a regional market as well.

Mr. Sargent: Do the chains get the same shake as a municipality?

Mr. Duda: They have to rely on two sources of funding. The municipality will purchase service from them on a per diem basis, and they have to rely on parents who place their children there and the parents pay the fee. The municipalities only pay the fee when the family is needs-tested; so it is only for those.

Mr. D. S. Cooke: Do you have information on the wage rates of the private sector versus the municipal sector?

Mr. Duda: No, we do not have an exhaustive list. We have some idea of the per diems in the two and there are some differences. From our limited sample, it is a function of lower salaries.

Mr. D. S. Cooke: It is.

Miss Stephenson: That should be available through the research department of the Ministry of Labour. I know they have for several years kept a record of voluntary admissions.

Mr. D. S. Cooke: I would like to see at least something on that, because every time it comes up at the municipal level you hear municipal councillors saying how efficient the private sector is in the day care field, when the reality is that it is cheaper because it pays employees very low wages. The municipal employees do not get paid great bucks but they get paid more than in the private sector.

Mr. Chairman: Let me interrupt for a moment. We are now at 12:15 p.m. We can continue, if that is the committee's choice, or we can have these people come back after lunch and tell Dr. Mustard to come a little later. If we are going to go that route, probably the better thing to do, if it is possible, would be to have these people come back and do the rest of it after Dr. Mustard has finished. What is the wish of the committee? I have given you three options, A, B or C; multiple choice. I am dying for a cigarette too.

Mr. R. F. Johnston: It does not seem to me it will take us that long to go through the last section of Mr. Duda's report. Why do we not start off with it? Dr. Mustard has been around committees in this place for a long time and will not be surprised at waiting half an hour to get started.

Miss Stephenson: You can reach him by phone and tell him that.

Mr. R. F. Johnston: Sure.

Mr. Chairman: Do you wish to recess now and come back? We have finished day care, have we not? Are there some more questions?

Miss Stephenson: Have we finished?

Mr. Duda: Yes.

Mr. R. F. Johnston: If we can produce some questions that have not been posed by others by the time it is over, we could add them as a list of things the ministry might come back with, rather than taking a long time to ask the questions.

Mr. Chairman: That might be a good idea.

The committee recessed at 12:17 p.m.

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SELECT COMMITTEE ON HEALTH

COMMERCIALIZATION OF HUMAN SERVICES

WEDNESDAY, AUGUST 27, 1986

Afternoon Sitting

SELECT COMMITTEE ON HEALTH

CHAIRMAN: Callahan, R. V. (Brampton L)
Andrewes, P. W. (Lincoln PC)
Baetz, R. C. (Ottawa West PC)
Cooke, D. S. (Windsor-Riverside NDP)
Johnston, R. F. (Scarborough West NDP)
Poirier, J. (Prescott-Russell L)
Polsinelli, C. (Yorkview L)
Reycraft, D. R. (Middlesex L)
Sargent, E. C. (Grey-Bruce L)
Stephenson, B. M. (York Mills PC)
Turner, J. M. (Peterborough PC)

Substitutions:

Dean, G. H. (Wentworth PC) for Mr. Turner
Hart, C. E. (York East L) for Mr. Poirier

Clerk: Deller, D.

Staff:

Fooks, C., Research Officer, Legislative Research Service

Witnesses:

From the Ministry of Community and Social Services:

Duda, G., Assistant Deputy Minister, Community Services Division

From the Canadian Institute for Advanced Research:

Mustard, Dr. J. F., President

LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON HEALTH

Wednesday, August 27, 1986

The committee resumed at 2:10 p.m. in committee room 2.

COMMERCIALIZATION OF HUMAN SERVICES
(continued)

Mr. Chairman: Welcome back, Mr. Duda. Okay, play ball.

Mr. Duda: The last section to be presented is the area of family support involving three services, two of which are from time to time provided through the for-profit agencies, halfway houses and group homes, municipal hostels and purchase of counselling.

Halfway houses and group homes are funded under the Charitable Institutions Act. This is a service that is provided to three groups of individuals, one on the basis of rehabilitation of ex-offenders, the second to people suffering from substance abuse, substances such as alcohol and drugs. As you probably know, the Ministry of Health funds detox centres. We consider these longer-term recovery and rehabilitative in origin. The third is a population known as socially disadvantaged, which might be better described as ex-psychiatric.

The reason we have provided this is that you requested all programs related to alcohol recovery. None of these services is provided through the for-profit sector. The very nature of the Charitable Institutions Act precludes that possibility. In your fuller consideration, you may want to know about this service sector.

As you will note, there are 42 homes, most of which are in the alcohol recovery area. That encompasses more than 667 subsidized beds, with a total capacity of 943 and a budget of \$6 million.

The next service is residential in nature. It is municipal hostels. We have some data that were collected five years ago in a survey. It may be useful to jot that down or, if you require it, I could have it written and sent to you. At that time there were 300 hostels, approximately 12,000 beds, as noted on the second page, servicing approximately 135,000 people in that year. They are funded through municipalities under the auspices of the General Welfare Assistance Act. The per diem is \$25 and we do not have any statistical breakdown of the number of hostels that are for profit or nonprofit in origin.

We are going to review the characteristics of the hostel program again and we are going to conduct a survey over the fall months. Should the committee wish it, we could include that consideration of collecting data in our collection, separating the nonprofit from the profit, and provide you with that as well as other information relevant to this residential service.

The last is a program which is for the most part purchased through the municipality. It is counselling that is purchased on behalf of social assistance recipients. The municipalities use the auspices of the General Welfare Assistance Act. When we provide similar services, we use the ministry act. I have additional information, data that have been provided that might

help in your deliberations. The budget: total expenditure in purchase of counselling is around \$6 million; \$5,886,000 is provided through contractual arrangements with the nonprofit sector; \$131,000 is through the for-profit sector, and that is through four separate agencies. Two are professional individuals who provide counselling on a purchased basis. Of the other two, E. Tand B. Association in Ottawa has an \$800 contract to provide service in Renfrew county, while the Ontario Family Guidance Centre has a contract of \$65,000 to provide counselling services.

Approximately \$66,000, then--

Mr. Sargent: What are we supposed to follow here?

Mr. Duda: This is the last section in our outline in the black book. The additional data were not provided, but I thought I would supplement what was already given with that small bit of information. It might be useful and, should you want it, we will provide it as an addendum to the last section.

That takes us through the presentation. As you will note, we did not elaborate on the most significant service provided by the ministry because it is entirely nonprofit by its very nature: our income maintenance system, the general welfare assistance and the family benefits allowance. There is no need to elaborate on those two services for the purposes of the committee.

Miss Stephenson: I have a question for clarification. I am referring to the first section; I believe it was the second portion of your remarks on the organizations providing halfway houses and group homes. You gave us a figure, which I did not get, about the amount of money expended. I am not sure whether it was for alcoholics or for the other two groups.

Mr. Duda: That was for all. There is a \$6-million expenditure for the whole program.

Miss Stephenson: Thank you.

Mr. R. F. Johnston: It would be useful for us to get a copy of that report done four or five years ago on the hostels. It is out of date now, because a fair number of beds have been added.

Mr. Duda: Oh, for sure.

Mr. R. F. Johnston: However, members might be interested in seeing that.

Miss Stephenson: Comparing it with what is going to be produced would be useful.

Mr. R. F. Johnston: Yes. The standing committee on social development received it when we were dealing with battered women and that side of the hostel thing. It was an interesting report. I am sure the members would be very grateful if you gave us that updated information this winter.

Miss Stephenson: How long will that take?

Mr. Duda: I believe it will take most of the fall, because a significant amount of information has to be collected. As well, as Mr. Johnston indicated, there have been quite a few changes since 1981. It was a \$14-million program then; it is more than \$30 million now.

Mr. R. F. Johnston: The other thing I would really like to see is a separation of the straight, transient-type hostel and accommodation for battered spouses. Lumping them together always seems inappropriate to me. Their functions are so dramatically different, in most cases. Will you separate those for us when you bring that out?

Mr. Duda: Yes. The transition homes are separated. You would probably want them separated into three categories: the homes used for very short-term stays, the domiciliary hostels, which tend to be longer-term, and the facilities provided to victims of family violence.

Mr. R. F. Johnston: When we talk about purchase of service, do some communities purchase service from private boarding homes for this, or, when we are talking about for-profit, are we talking about some of the spillover in hostels and that kind of thing? I know that approach is being taken in some areas.

Mr. Duda: I believe some of them are individual boarding homes. Others are rest homes. The rest homes are the beneficiaries of some of this funding, albeit \$25 per day. That would be typical of the service providers in the hostel sector, as I think I understood your question.

Mr. R. F. Johnston: Yes, you did. Did you say there was a purchase of approximately \$6 million in counselling?

Mr. Duda: Yes.

Miss Stephenson: Of which \$131,000 is directed towards the for-profit sector.

Mr. R. F. Johnston: Yes, this tiny group. Can you give us some explanation of those few you mentioned at the end? There is the one that is operating in Renfrew county for only a few hundred dollars; then there is the other one that is operating for \$65,000.

Miss Stephenson: E. Tand B. something; I am not sure.

14:20

Mr. Duda: I will have to get you a rationale. Guessing at it, it is the absence of other service providers who are willing to provide services. There is probably no family service organization available in Renfrew, or there may be similar considerations, but I can get you specifics in both the Ottawa and Halton situations.

Miss Stephenson: The other one is in Halton?

Mr. Duda: In Halton, yes.

Mr. R. F. Johnston: That is what I was going to ask. If a place such as Halton does not have it, one would expect places in the north would not have it either and would be having to do the same kind of purchase. That is why it is fascinating. It is such a tiny fraction of it.

Mr. Duda: We can get the information. I do not have it.

Mr. Sargent: Sorry, I missed that. What is the funding formula for a halfway house?

Mr. Duda: It is a fixed per diem under the Charitable Institutions Act. I believe it is \$33.50 per bed per day, and we provide that level of financing.

Mr. Sargent: What is the breakdown of the \$33.50?

Mr. Duda: I do not have that information in terms of how much for staffing and--

Mr. Sargent: I mean the federal-provincial breakdown.

Mr. Duda: Okay. That is 50-50 federal and provincial.

Mr. Sargent: Nothing from the municipalities?

Mr. Duda: No, they do not involve municipal financing.

Mr. Sargent: What about capital?

Mr. Duda: We have provided capital. I believe that is on a per bed basis. We have a limit per bed to construct new halfway houses, although this system has not grown or expanded at all in the last seven or eight years. In fact, one of the service systems has been frozen. I believe the one in the alcoholic recovery home has been frozen since the late 1970s. Offhand, I do not know the capital funding formula, but I can provide it to you.

Mr. Chairman: Are there further questions from members of the committee? Seeing none, I thank you for coming and making your presentation.

Miss Stephenson: There is a place near North Bay that is run by a priest and that I believe falls under the halfway house project.

Mr. Duda: St. Leonard's House? Is that it?

Miss Stephenson: No.

Mr. Duda: Do you know where it is?

Miss Stephenson: I wanted to know where it is, because he was attempting to expand it. I will try to find the name.

Mr. Duda: I do not know it offhand.

Mr. Chairman: Perhaps I could ask a question before you go. Take a place like the Donwood Institute, which is obviously a private clinic. If there is any participation, I gather it would be that of the Ministry of Health rather than you people, since you have indicated it has to be a charitable institution for you to--

Mr. Duda: Yes. Right.

Mr. Chairman: Thank you very much.

Miss Stephenson: Donwood is a public hospital with a clinic arrangement attached now. It has been that way for--

Mr. Chairman: Do people pay to get in there?

Miss Stephenson: You can for the long-term care program, yes.

Mr. Chairman: What if you cannot afford the long-term care program?

Miss Stephenson: Then you can be taken in on a family grouping and that sort of thing.

Mr. Chairman: I would like to see an extension of that program. That is probably one of the best self-help programs in Canada.

Miss Stephenson: In the world.

Mr. Chairman: In the world.

Miss Stephenson: Yes. Bellwoods is the extension. It is the new development that is primarily ambulatory, although it has been granted 12 beds by the Ministry of Health as well. Gordon Bell, who started Donwood, is now running Bellwoods.

Mr. Chairman: Is his daughter the girl who swam Lake Ontario?

Miss Stephenson: No.

Mr. R. F. Johnston: I want to make a comment on that last presentation. I found that for our purposes of getting an overall framework, its organization was better than that of the Ministry of Health presentation.

Miss Stephenson: The only thing lacking was financial information.

Mr. R. F. Johnston: Exactly.

Miss Stephenson: Otherwise, it was good organization.

Mr. R. F. Johnston: I liked the organization of it.

Mr. Baetz: There seemed to be a better attempt to zero in on the questions.

Miss Stephenson: Yes. I suppose the difficulty is that in the Ministry of Health the areas are so big that trying to narrow them down is difficult.

Interjections.

Clerk of the Committee: Dr. Mustard is here.

Mr. Chairman: Dr. Mustard, will you come forward?

Dr. Mustard: Are you ready for the next victim?

Mr. Chairman: You have nothing to fear from this group.

Mr. R. F. Johnston: Pussycats.

Dr. Mustard: I know some of the people, so I will not be able to make a judgement call on that one publicly.

Mr. R. F. Johnston: Not only that, but she requested that you come before us.

Mr. Chairman: Do you have an opening statement?

Dr. Mustard: I have a comment I can make. I wrestled a little with your terms of reference, and I must say they are not entirely clear to me.

Mr. Chairman: You are probably not the only one who finds them unclear, Dr. Mustard.

Dr. Mustard: My interpretation of them and my remarks will be related to that.

Mr. Andrewes: It is a measure of our success if we confuse you.

Dr. Mustard: I am going to take your concern over the role of the commercial for-profit sector of health and social services as opposed to the not-for-profit argument. There are differences between public financing of the for-profit sector as opposed to private financing of the for-profit sector. I am going to take the stand a little bit that when you are looking at public financing, which gets into a for-profit thing, it is a different type of a question than if it is private financing of the for-profit sector.

I am going to try to go through this with you in terms of the health area. In doing so, I would like you to think a little about the value structure of our society, because that is a powerful determinant in how you handle it and how much is acceptable within our society. I would take the stand that, in contrast to the country to the south of us, we have a stronger collective sense of values than the Americans. The individualistic value is more dominant in that structure. We have respect for individual values, but basically we have tended to leave all those within a broader collective sense of responsibility and things in society. When you are trying to talk about health and social questions, one has to think about that value structure.

Then there is another area, which in some ways is not as important to health but is important in other ways. It is society's sense of future values. Where that comes into your debate, in my judgement, is that a society which has a strong sense of the future is concerned about its investment in the young. However, your health sector is concerned predominantly about investment in people my age and older. One of the powerful steering effects in society as you get into this is whether groups most dominant politically may steer your resource allocation. I do not know the data for Canada, but I do know the data of the United States, and there has been a powerful shift of resources from the young to the old that has severely hampered the development of the next generation in the US. It may have some difficulties coping with competition from other countries in the face of that.

As you are going through this, I would ask you to--as you obviously do as politicians--keep in mind the value structure of the country but do not lose sight of the importance of future values in the decisions that are made. Having sat for many years in an educational health environment, I was more than alert to the enormous shift of resources to the health sector in contrast to those in the educational domain. I am very fearful that the pressures of an ageing population may substantially increase that in our society, much to the detriment of our future.

Finally, I would like to come to the issues of efficiency and innovation. My remarks are directed at two substantial changes that are taking place in society. One is, I think we are all aware that the amount of money you can allocate in a service industry, such as health, is really related to

your success in being able to generate wealth. Indeed, the strongest correlation to health care expenditures is the percentage of gross national product. It is not the kind of ideology that governs the health care services; it is the actual per capita wealth of the country. Therefore, to have efficiency in health care and in social services is of enormous importance, just as important as in the manufacturing industry. Perhaps the biggest stumbling block we have all faced in the service sectors and in human services has been how to get efficiency incentives into those organizations.

14:30

Finally, the solutions to providing care and support to people cannot be left constrained within existing boxes. We have to think through new solutions and we have to find ways to make innovation possible. One of the constraints with the current method of funding of health care, which I think you are all familiar with, is it essentially freezes the system. It makes the ministers of health lightning rods for the professional groups that are being affected by some decision of government. If you think through the debates that have gone on over the years among the hospital sector, the Ontario Medical Association, the nursing sector and the Minister of Health, be he Conservative, Liberal or New Democrat, I think you can well document that historically for the past 15 years.

That is not surprising. It is true in the British system as well because the minister, by being the person who allocates public funds for the services through whatever channels, has to become the instrument for suggesting change, which creates polarization between the group that is being affected and the minister. Innovation requires change.

I argue that the current arrangements essentially freeze the system because ministers find it very difficult to do that. I got attacked by a former Labour health minister in Britain at a meeting I was at last fall when I brought this forward. He said, "It is a good thing that the minister is a lightning rod." I said, "You may think so, sir, but the nature of the changes that are taking place and the fact that the minister is essentially boxed in substantially justifies the case that you have to find ways to create a system that allows for innovation to take place."

Within that framework of points, I would like to talk a little bit about for profit and not for profit in our health care system and perhaps use the terms a little differently to just making profit, but how to rearrange a system to achieve incentives for efficiency, for innovation, taking into account the value structure of your society.

If you take medicine first, the determinants of the quality of care that are provided are how your physicians behave and the efficiency of the system is determined by how your physicians behave, how they marshall the use of resources, etc., in the system.

We have seen developments south of the border that in some cases are extraordinarily interesting in what is taking place. We have seen enormous debates within the British system, which may or may not be leading to satisfactory solutions. If you talk to the Swedes, you will find the same debate going on. It is how, within the different arrangements for funding health care, you can create incentives for innovation and efficiency. The thing about the American system that has perhaps captured the most interest is the health maintenance organization, which can be for profit or not for profit.

Essentially, in the thing called the Mustard report in 1974, reading back over it, it seems to me that we were essentially arguing for an HMO kind of system. We wanted a board to operate a health care delivery system in an area and we would be competing with another one down the road. I will not tell you about the bruising battle of trying to get my professional colleagues and hospital board members to understand that, let alone the rest of the world, but in those days it was not very saleable.

In essence, that committee understood that--

Mr. Chairman: Excuse me, Dr. Mustard, perhaps I can interrupt. I do not want to deviate from what you are saying, but why was it unacceptable at that time? Was it because there were not enough doctors to create the competition that might induce them to go into such a thing?

Dr. Mustard: Let me give you a bit of the background of an HMO. That will allow me more easily to answer the question for you.

The principle we adopted in that committee was that physicians should operate in a system and be accountable to the system. In essence, that is what we said. They said that hospital boards or the boards over hospitals and the services delivered in an area should have broad responsibility and accountability, and that physicians should be under incentives to be efficient in that structure. What that meant was physician accountability to objectives within a system.

It is my own reading that part of the concern this spring with the OMA and the government may have been about extra billing, but it really was about the change that is taking place even in the United States about the social-political climate in which a physician operates. In an HMO system, a physician is in a governed group practice, either congressionally governed or maybe governed by another group of people, which has a high level of accountability in terms of performance and peer pressure on performance.

I know one of the reasons we did not get much support. My colleagues in the profession sensed that is what it meant. It meant a transition of roles in society. The other reason, which surprised me, is that the hospital association boards saw this as some kind of threat, which I still do not understand. It absolutely baffled me as I went around the province talking to hospital boards.

They could understand their hospital. It may have been that there is a belief that the hospital is a place where you cure disease and the rest of the function is unimportant, a lack of understanding at that time about the importance of delivering care in the community. A classic example is a person with chronic chest disease. Properly sustained with adequate support in the community, he or she can be kept out of hospital, but if that support is not there, he comes into hospital. It may be the belief of the people in the hospital area that this other area was not as important and not something for which they should have a responsibility. It is an interesting thing for which I still do not know the explanation.

There is professional resistance because it represents a substantial change in how physicians have to work in the future. The private, for-profit sector in the United States is putting this pressure on them, or non-profit. I think we did not explain ourselves well enough for the hospital boards and administrators to understand us.

Miss Stephenson: I do not think that is true. It is a very readable and very understandable report.

Interjection.

Miss Stephenson: Yes, thank you. As a member of the committee, I reject the chairman's statement that we did not make ourselves understandable.

Mr. R. F. Johnston: I found it easy to understand.

Mr. Chairman: I missed what you just said. Did you say the pressures put on the medical profession by the profit and nonprofit in the US is greater than the situation here?

Dr. Mustard: If you go into a for-profit HMO or a nonprofit HMO, you go with the Kaiser-Permanente setup, for example. They know pretty well which medical interventions are effective. If you start using interventions which are of questionable value, you will be picked up in their system. Nobody picks up very many physicians in our system who do it. You can still engage in practices of which you might debate their real value. They are not doing any harm, but the question of whether they are of value is there.

Second, if their alternative forms of delivering that care achieve the same objective of helping the individual with his illness and you use an extraordinarily expensive one when you could have used a far more suitable lower-cost one, you will be picked up in the system. Therefore, the physician is under pressure to deliver quality care efficiently. That means you have to be thinking about how you relate to the other groups that work with you to stay in an effective program. That is a form of accountability. Depending on the kind of practice setting you are in, you have more or less of that pressure on you. Many physicians work very conscientiously at this--do not misunderstand me--and the system. It is a form of having to make a commitment of yourself to working in that kind of environment. Is that clear?

Mr. Chairman: Yes.

Dr. Mustard: If you look at the three major issues our societies face, the first is, how do you care for an ageing population that becomes an increasing proportion of your population, in which two things are occurring? One is that they are losing the vitality of their organ systems, which is a normal process of ageing and not disease, and, second, the incremental effects of disease in that process.

This issue is important and, in my view, it is important not to develop systems that lead to medicalization in the supportive health care for older people. You have to meet that challenge in a society in which the normal kin relationships are radically changed from what they were 30 years or a generation ago. You have to cope with that challenge, and I think it requires innovation and sensible approaches to doing it. I will come up with some suggestions one can think about in another comment I am going to make.

The second issue is that all developed countries are fighting like hell to create ways to generate wealth in a rapidly changing global economic world. Ontario, as the Premier has announced, is obviously caught within trying to meet that challenge, and that challenge is complex. It will require an investment of resources, which may have to be done in a way that we have not done in the past to be successful. That may have to have a higher

priority in our society than our social service sector, because if you cannot generate the wealth, you do not have the money to put into the service sector. It is a tough and complicated question and one which I do not think any country has satisfactorily solved yet, but there are indicators of approaches that can be taken. That is an enormously important issue.

Coupled in with that is the third point, that the amount of resource you can put into the health and social services will really be governed by how successful you are in the second part. It is important to look at ways of letting those services become efficient, seeing if you can get productivity increases in them, if I can use that term, to allow innovation to take place.

If you put that forward and try to do it within my earlier comments about the structure of our society and its values, I do not think you could easily transfer our system to a private, purchase-for-profit system. I think you would have problems in being able to get that into the system without creating substantial social inequalities, etc., in society. You might really steer society into a two-tier society, which is the risk we face for other reasons, but nevertheless you would run into that type of a problem.

Can you introduce market forces into a publicly financed system or a mixture of public and private financing which can create incentives for innovation and efficiency? I do not know whether you have had a chance to look at this thing that Alain Enthoven did for the Nuffield Provincial Hospitals Trust. Alain Enthoven is one of the good American minds from Stanford University, who has tried to look at this question in the professional field. He has been a strong developer of the whole health maintenance organization approach in the health field.

He spent a year in the United Kingdom as a guest of the Nuffield Provincial Hospitals Trust. This report is how to try to introduce incentives for efficiency into the United Kingdom's National Health System. Therefore, he is trying to put into a publicly funded system things that you traditionally see as being associated with a for-profit sector in the classical sense of that.

It is a thoughtful paper. It has some suggestions for the UK system. Whether it is doable or whether anything will be done on it is hard to say.

Mr. Chairman: Perhaps you would make that available to the clerk afterwards and we could have copies made.

Interjection.

Mr. Chairman: Do we have it already? I did not see it.

Dr. Mustard: The second document I have on the subject--and I will leave it for you to have copies made--is by Ted Marmor, who is a professor of political science at Yale University. It is a draft of a paper he sent me looking at the for-profit and not-for-profit health care units in the United States, comparing the pros and cons of them.

Ted is a Democrat. He worked for those previous Democrats in the 1970s. You can argue that his biases are in that direction, but it is an interesting piece. He is fairly objective about the pros and cons. This is obviously an American culture which is different from ours, but he does point out some of the strengths of the for-profit aspect and the US system.

Personally, I do not think it is that transferable to a Canadian scene, but it does have some messages in terms of at least paying attention to the questions for innovation and efficiency in the system.

Finally, I am sure you have this from my old colleagues at McMaster, Mr. Stoddart and people such as that, who have said many times about how you might within a publicly financed system introduce systems to create efficiency and innovation in the system. The time has come to give those a hard look. If you go through the Stoddart approach, which is a modified HMO approach, thinking about it in terms of health care, a government could franchise the delivery of care to groups in the community.

It would have to have legislation to cover this. It would have to have a requirement that we would all probably buy into a plan annually. It would have to have a system of financing that provided a tax credit, perhaps even a negative income tax philosophy to it. But I, as a consumer, would decide to buy into your plan as opposed to hers. You would have a cost for that which you would have to set for your plan and you would have, therefore, under the law, to contract to give me full services for the things that are enacted in the franchise.

Something such as that could be developed. Very much came out of our health planning task force on this which has created that type of capability. If one did this, it might be doable and it might work. It might have a mix. If I were in the lower-income classes, I would get my tax credit for the average cost of the plan.

Mr. Sargent: We know all about that.

Dr. Mustard: If I wanted to go to his Cadillac service, I might have to top it up with \$150 to be able to buy into the plan. In other words, you could have some flexibility in trying to look at it that way.

One of the reasons that it might be right to introduce this type of concept is that I think the limits of medicine are better understood by society than they were 15 years ago. Medicine provides care to and support for people who are ill, but there are limits to what it can do. It is not primarily the preventive aspects in the health field. If you are trying to get incentives for efficiency, having different plans and trying to do things with some flexibility to do them, you then free the minister up from his office being polarized every time somebody wants to make a change.

Let me give you one example of this. At McMaster, we practitioners developed the concept, working as physicians in the community, and demonstrated that indeed it worked and that we provided an advantage in terms of scope of care that can be delivered to the community. It has really been very difficult to introduce that concept into our system, and yet the health maintenance organizations in United States use them as practitioners. There has been no problem introducing them into the more diversified US system, which is a rather interesting aspect of a system that is not as locked into a separate public funding approach to doing it.

I guess I am arguing--if you are thinking about this--that you want some of the principles of the marketplace, but you are probably going to be constrained to have to do that within the cultural ethos of your society. The real challenge is to pick up the type of concept Stoddart has been arguing for, to introduce market forces into a publicly funded system that becomes

more decentralized. Nobody knows whether that will work. It has not even been tried, but at least you can think it through and try to develop it.

Then you come to the second side of this equation in the health side, the older person and the lack of kin support. According to the figures I have, there is the risk that we will maintain one of the highest institutionalization rates for older people of developed countries. I do not like that because I am getting into that age group. Some of you will say I am already there, but at least it worries me. If we cannot solve what I call the nonprofessional support function for older people, we run the risk of increasingly having to institutionalize them.

One of the interesting approaches you can take in a society is to recognize that probably the most important advocate and support for an individual in a time of need is a friend, who may be a kin but who may not be a kin. How do you organize your society to optimize that being provided for somebody in a time of some need? I am not talking about professional care. I am talking about the type of support or care that women have traditionally given in this kin sort of system. That may still be the large part of it.

There is a second issue in this. In doing this in our society, women have tended to have to drop out of their employment to provide it. They have had to pay an economic price for doing it. They pay a price in pension benefits as well, and since women tend to live longer, that is probably not a good thing to happen in our society in the long term.

One approach one European country has discussed in handling this is very interesting. It is to recognize the advantage of having someone who really is a strong friend being able to come in to do it and to recognize the need to maintain the economic support to that person. This comes out of Sweden and it comes out of an analysis that in its society the impact of the automation robotics revolution will lead to about 10 per cent technological unemployment in the next decade. Given it is successful, they are still going to have substantial displacement from the conventional blue-collar working structures in their society and perhaps in their service sector as well.

14:50

They have done some analysis, and I cannot vouch for the good or the bad part of it; you may know about it already. If I am to take time off to support a friend in a time of need, then maintaining my income, which maintains all my fringe and pension benefits, etc., is better than having to transfer the person into some system that is there to pick up the care function. In other words, the economics of maintaining my income as I go to provide support to that person turns out to be just as sound as any other way you can do it. Obviously, there are all kinds of complicated things you have to sort out in terms of rules, etc., for doing this. It has the advantage that you optimize your capacity to care for the person in the community.

It has the additional advantage that a friend can be the advocate when you go into the professional care component that has to be brought to bear on it, whereas if you have to dump the person into a substitute for the care provided by a close colleague in supportive care for a friend, you run the risk of professionalism taking over, which may be a disadvantage in terms of people who have chronic home problems and need support.

I am only introducing the idea to you to say that when you are trying to think through what you should be doing in terms of long-term policies, you

should not only think it through in terms of the world as you understand it today but also try to think it through in terms of the world that is going to be here within 10 years or probably less. Perhaps it is already with us.

Given that, perhaps we have to think of some imaginative new ways to provide the support people need in society, particularly in the older age group. If you can do that, you may create a different way of handling problems, one that may be very human and sensitive to the needs of individuals and probably pretty effective in providing the support people wish to have.

That has not given you a package of whether I am for for-profit or not-for-profit in the system.

Mr. Chairman: It is very thought-provoking in any event.

Dr. Mustard: There is no easy solution to your question. I hope you will think this through in terms of the kind of society we are and the changes that are taking place and will recognize that there are advantages to introducing what I consider to be legitimate market forces in the health services field. However, the constraint on your creative aspect in doing that is that you probably cannot introduce it simply by going to a for-profit kind of system. You have to think of a more sophisticated way of doing it at this time in our culture and our past.

Miss Stephenson: Have you thought at all about the implications of introducing those market forces in our traditional social services delivery system? Have you thought about ways in which they might impact and whether it might be feasible to do it? There is probably a significant degree of resistance to that kind of concept.

Dr. Mustard: I have thought about it only in terms of the social services that are linked to the health centres. You need to marry them together for the optimum effect. When you come into the more complex areas, when you start to deal with the handicapped and problems in that area, it is perhaps not as easy. That might be very difficult.

If one starts to think about it, there might be strategies that could be developed. I suppose there is no reason why one could not have competing plans even under public financing for the provision of care to the handicapped where somebody buys into the plan in terms of the kind of handicapped and what is involved. Obviously, the issues and handling them are a little more complex.

It is an interesting question. I do not have any concrete suggestion, except I suspect that once you start to look at it, you may find there are some interesting approaches you can take.

Miss Stephenson: Developing some models in the other sector might be of assistance in examining the ways you could do it in there.

Dr. Mustard: Yes.

Mr. Andrewes: I was interested in your comment about the nurse practitioners and the resistance we might have in our system towards that sort of profession. Have we developed a professional mentality towards health care, so much so that we resist even indulging in a measure of self-analysis and self-treatment?

Dr. Mustard: No, I do not think it is too complicated. In any organization that is centrally funded by an agency, whether it is funded by

the government or by GM, when you try to introduce changes that affect the balances that exist, there is going to be some resistance. You know very well that an organization trying to manage change has to use very skilled personnel to do it. Since the government does not really run the health care system--it only funds it--it is attractive to put management skills into trying to produce this.

When you run a decentralized health care system, such as the HMO system in the United States, my plan may say, "Hey, we would like nurse practitioners because this allows us to provide more care." You may say in your plan: "Bullroar, who wants those second-class people? You are going to go down the drain." You might find out after watching us for a couple of years that our nurse practitioners are getting us more clients because we provide a higher level of satisfaction to everybody and we keep our costs down; then all of a sudden your plan may change.

The polarization effect there in terms of change has to be taken at the sublevel of the units, and I may fail because there is a risk in change. A government has to abhor risk. You know what happens if the government makes a mistake--it is yapped about in the House for the next two weeks--whereas if somebody outside does it, "That is all right; that was just a failure."

Decentralizing your system and putting elements of the marketplace in competition would allow the nurse practitioner thing to emerge, if that were a satisfactory thing. I do not think the profession would resist it within a more decentralized system.

Mr. Andrewes: From the standpoint of a lay person, is the majority of society in Ontario willing to accept market forces in a health care system, or are people still hidebound to the concept that if they do not have health care delivered by a professional, and that usually means a medical doctor, they are not getting the proper care?

I run into a number of people where perhaps the doctor tells them the facts of life and they do not like it; so they go to another one simply to try to find someone who will sympathize with them.

Dr. Mustard: Sure. That will occur in any system. You can put rules on it to balance off how you handle it. As I recall, our experience with the nurse practitioners in the Niagara Peninsula area, whatever that population is like, was that there was no problem.

Mr. Andrewes: I am one of them.

Dr. Mustard: It took six months to a year to get adjusted to it. Once it gets in there, some patients will swear by the nurse practitioners because in essence they get more sympathy and understanding from them. What it does is enhance your capacity to do that.

The experience has been that it works for a large part of the patient clientele but not necessarily for everybody; there are others who want a certain kind of thing. When you have people with chronic disabilities or chronic problems, which need continuing care, it becomes a very effective way of doing it. You get the sympathy and the understanding and you can put the continuity behind it. The physician has more constraints on being able to do it, even if he wants to do it.

Mr. Andrewes: I would like you to explain a little more fully for me the role of the advocate in relation to the ageing person. Perhaps an example might help.

Dr. Mustard: Obviously, I am not a practising physician any more. The only thing I do is get phone calls from friends. I dealt with one this morning about guidance in terms of professional care that was required.

Miss Stephenson: "My physician has said I should be doing this. Do you agree? What do you think?"

Dr. Mustard: Even more it is: "Where should I go? Who should I meet with to solve this problem?" An advocate who has some understanding and who is not at quite the same threshold of having to have something immediately can think that through and do a bit of digging to try to provide some guidance for the person.

You try to have some understanding of what the system requires so you can help. Can an advocate do that? Sure. I watched my wife looking after her 96-year-old father and mother in Ontario. She is an advocate about the health care system in London, Ontario, in terms of its interaction with her father. Sure, I gave her a bit of backup from time to time, but in effect she was fulfilling that function in a kin relationship to ensure that he was not trapped in systems that were inappropriate for him and that there was some sense of balance kept in the system.

15:00

Mr. Andrewes: Are you saying we should not economically penalize the advocate?

Dr. Mustard: Yes, the person who has to do that. I do not know the Canadian figures in detail, but essentially this has been largely the role that women have played in society. You now have a much more equitable society in terms of opportunities for men and women. In our generation, if a woman drops out of the labour force to provide that care, she loses her income and her pension benefits, which she may have been accumulating, while she provides that care, but she is doing an all-important service not only for her friend but also for society in providing that.

The Swedish argument is to recognize that; recognize the change in kin structure that has taken place in society. Why not capture that as a "new employment opportunity" in society? In effect, with the change in the nature of the labour force and opportunities, people need to do things that give them satisfaction. Providing care to close friends provides satisfaction. There is no doubt it provides recognition and gives a sense of worth. It has a very positive impact on human beings.

Rather than trying to institutionalize that form of care as a quasi-profession, the Swedes are toying with the idea of leaving it with people interacting with people. That is the way to do it economically, because one of the things that is taking place is that, if you look at the economics of the world today, manufacturing no longer increases employment. The truism of the 1980s is that manufacturing increase and productivity are now disconnected from employment and will continue to be.

Mr. Sargent: Go over that again.

Dr. Mustard: In the question of manufacturing, producing goods and wealth, the drive taking place in the world is such that this will no longer create employment; it will create wealth, but it will not create employment. What you and I experienced out of the Industrial Revolution, in which

manufacturing things was associated with increasing employment, has been radically changed through the impact of automation robotics. One calculation is that somewhere around 2010, probably most of the conventional jobs you and I know about in the resource-based industries and manufacturing will disappear.

You can say in some ways that is a bad thing. I have had some long debates about this with some of my colleagues, including my wife, who does not agree with me on this. However, I point out to her that for 30 years I have been one of the beneficiaries of the Industrial Revolution. Essentially, I have done things I would like to do rather than doing jobs. I had a job for only about four years. I got out of that, and the transfer of wealth in our society has allowed me to do that.

The real problem is, given that you can generate wealth and that you are going to have the industries to produce the wealth, you now have to talk--and I do not ask this committee to talk about it with me, because I do not want you to do it--about how you transfer wealth into society for people to use.

I raised this question at the Couchiching Conference this summer, and one businessman said, "Do you mean if I am able to generate all that money, I cannot keep it?" I said: "How can you keep it? You are not going to have any kind of society to interact with you if you keep it. You have to find ways to distribute that wealth in society."

Mr. Sargent: To recycle it.

Dr. Mustard: That is right. I do not know the solution to that.

This Swedish approach is a way of allocating resources in society. It is allocating it through individuals--privatization, if you want--but within a social policy fabric that the collectivity of the states is setting up to do things.

Mr. Sargent: That is very interesting.

Dr. Mustard: The thing that concerns me most--and some of you know what I do; I spent four years criss-crossing this country trying to put into place an institute for advanced research--is that it is mind-boggling where our country stands in trying to meet these challenges. There are not many people who sense the challenge and the real problems that have to be faced.

As legislators, your job is even tougher, because you cannot move until the public's perception gets up to the point where you can do something. Still, you face an issue that is of fundamental importance. All I am arguing is that you have to recognize that somewhere down there is a scenario that is taking place within a human generation, and you should develop this to make it possible for your systems to be able to adapt and adjust to those changes.

Mr. Baetz: I was very interested in your--

Mr. Chairman: Is that a supplementary, Mr. Baetz? I have other speakers on my list.

Mr. Baetz: More or less, but I will wait.

Mr. D. S. Cooke: I have read some of the experiences of HMOs in the US in Stoddart's report, and I have talked to Ted ??Goldberg and others who are great advocates of this. When one considers we had such a difficult time

with the whole issue of extra billing, not so much the ending of extra billing as all the fears that came out of that debate--government control of health care and all the other rhetoric that was used--how do you change the health care system in Ontario or in any other democratic society when normally it is only politically acceptable to deal with a crisis when it is a crisis but not to anticipate a problem?

Dr. Mustard: If you look at the story of the HMOs in the US, that process has been going on for 25 years or longer. At the end of the 1970s, I think fewer than five million people were enrolled in HMOs, and there was a large debate as to whether they would succeed. I forget which administration it was--it may have been the Nixon administration--that said in effect, "We support this concept." There was a public policy statement saying they supported it, and they probably put out a few incentives to facilitate the system.

As you get more and more people working within that framework, you become more comfortable and accustomed to it. More and more people want to do it. For example, if you talk to young physicians in some of the Minneapolis plans, which are among the more sophisticated and well entrenched, they will not operate under any other kind of plan. They can achieve the levels of satisfaction that professionals like to get out and deliver in health care because they are working in an environment where they have combined resources.

They do not have to worry about people within the community or when they have to institutionalize them. They feel they have a sense of responsibility and can be effective in what is going on, whereas here, when a specialist discharges his patient from the hospital and the patient goes back out into society, there may be no guarantee of the general physician the person can go to when he is dropped back into society, and that can be a less satisfying kind of enterprise.

Not all physicians are going to be concerned about that, but what happened as more and more people became familiar with that idea in the US was that it became more and more popular. Second, as consumers became more and more involved with this business, buying into it and getting the satisfaction from it, they started to want it.

Consumers who had been in Minneapolis went to Chicago, which did not have this kind of plan, and I gather that the growth of HMOs in Chicago in the past two years has been horrendous; they have grown exponentially. It is my understanding that some time by the end of this decade there may be more than 60 million Americans in some form of an HMO scheme. They range all over the place, from professionally controlled to nonprofessionally controlled. Some individual physicians operate a network, as in Oregon; it has fairly scattered communities, but the doctors operate as an HMO. They work that way and they back each other up with the resources to do it.

In answer to your question, the government could never initiate this on its own. It would have to say: "We think we need to create a more decentralized system that has some incentives for efficiency and for innovation. For those of you who wish to go this way, here are some opportunities and guidelines." You have to let it evolve, and you are going to have some loose ends as you let it evolve.

Mr. D. S. Cooke: In the US there are some major economic incentives. Health insurance is delivered primarily through companies and through union contracts, and health care costs were going so out of sight that the only way

the companies could provide some health insurance programs at any kind of a reasonable rate was through the HMOs. I am thinking primarily of what I have read about Michigan and the involvement of the United Auto Workers there.

Dr. Mustard: That is part of it, but it is a slightly different argument. It is important to remember that the percentage of the gross national product spent on health care in Sweden and the US is about the same. Most people forget that.

One is a solid, creative, collective society. I do not want to use the word "socialist," because Sweden is not really a socialist country in many ways. Any country that lets its big corporations keep their profits in a special, nontaxed pool to be reinvested in other things has to be a country with a lot of imagination.

By the way, do you know ASEA is doing the automation of the General Motors plant in Oshawa? ASEA is the Swedish robotics company. ASEA was able to do that because it had the wealth to create this sort of thing out of its resources. That is an interesting aside.

Because of that, the Americans had an extraordinarily heterogeneous system which had wild swings in it. It had portions of its population where there was no net to catch it all. They were simply out of it. It was bad. It had ridiculously expensive things that were absurd. Businesses and the unions realized they could get a hell of a lot better bargain, a more efficient service, out of the health maintenance organizations, and they went into them because they were pouring a lot of money into things at the high end of that unnecessary expenditure.

15:10

The characteristic of the American system has been enormous diversity with extremes and sections of its population being left out, but out of this has emerged some of the most efficient units for the delivery of care. As more and more systems come into an HMO framework, then their efficiency drive will be very powerful. The figures still stand up in the Rand Corp. study that an HMO framework produces about a 20 per cent to 30 per cent reduction in the utilization of institutional care facilities. That was essentially borne out in nurse-practitioner studies out of McMaster.

To get there, you have to be patient and you have to construct devices that will allow the society to move. The health service organization system that Ontario developed is an advanced step in that direction. I know one of the young physicians who has gone up to work with the unit in Sault Ste. Marie, and there are aspects of it that he as a young physician really likes in terms of providing care. I have no idea what it is like at the present moment, but that is the kind of framework, if you boost it along a bit more and allow it to take place.

In contrast to 12 years ago, I know there are hospital boards now that would be far more receptive to the concepts in the health planning task force report of 1974. You have to craft ways to be able to move into that kind of area and be creative about it, but do not expect the system to move all at once. Give it time to adjust.

Mr. R. F. Johnston: My question is a supplementary to that last part of what you were saying.

Mr. Chairman: Before you ask the supplementary, for the benefit of those who do not understand what an HMO is, could you briefly tell us what it is?

Mr. R. F. Johnston: We had a long discussion on it yesterday.

Mr. Chairman: I am sorry. Everybody knows except me.

Mr. R. F. Johnston: We will fill you in later.

Dr. Mustard: Let me try to outline how I see it.

Mr. Chairman: They keep the chairman in the dark.

Dr. Mustard: Let me help the chairman out. Let us suppose I run an HMO. Where do you come from?

Mr. Chairman: Brampton.

Dr. Mustard: You can come to Mustard's HMO, which includes an acute care hospital and a variety of care services, and you will buy into my HMO, say, for \$500. That will be your contract price for a year, and you will have to buy into it for a year.

Mr. Chairman: As a patient.

Dr. Mustard: As a client. You may not even use the services, but you buy into it.

Mr. Chairman: Like a driver's club or something.

Dr. Mustard: Yes. We are obligated to provide all the care requirements within our contract to you at no other charge. For your \$500 fee you get full care. If you come in smashed up in an automobile, you get full care. We contract to look after you.

You may find after a year that the guys and girls you have been associating with as professionals are a pain in the ass. They do not pay any attention to you. Dr. Stephenson's unit is also there and you are going to transfer over to her organization, where you will find sympathetic, understanding, loving, tender and thoughtful care. You decide that that is where you will go. She may charge you an extra \$50, so that you pay \$550 instead of my \$500. That is the kind of choice you have. You have a choice in the range of services.

There is enormous flexibility in this. These can be organized on religious lines. The Catholic culture can have its complete system; the Jewish culture can have its complete system. It can take care of the ethnic characteristics of your society if you so wish. You can have Cadillac psychotherapy services. I might have a service that is \$750 a year, because I do an enormous amount of supportive psychotherapeutic care for people. Who will pay? The people who want that. Indeed, I know some who want that. They need that and they will find the money to do it.

Let us suppose there were four plans in your area. One was \$400, one was \$500, one was \$550 and one was \$700. The average cost would be some figure around \$525 or \$550. Let us suppose I am a person who has no income or a

marginal income. Then I would receive a voucher or a tax credit equivalent to that average cost, which would then allow me to buy into at least two of the plans. If I wanted a hand-holding service, I would scrape together another \$200 for that if I wanted it. That is essentially the framework of how the HMO system operates. However, the doctor in that--this is where the for-profit question comes into it in an interesting way--is under two incentives. In most of the systems, he is paid a basic income, which may be 60 per cent of his potential income. The rest of it is determined by how efficiently the care is delivered.

Mr. Chairman: A dividend.

Dr. Mustard: Yes, you can look at it that way, but you have to watch out that the doctor does not shortchange the patient of legitimate care. Therefore, they also put a quality incentive on it. If you give bad care, you are also penalized. Thus, a doctor who saves on using inappropriate services or not using services is going to get penalized for not doing appropriate things.

This is where, as I was saying earlier, the monitoring function of the profession comes in, which is a thing the profession has to become used to. The docs who are in it and become used to it like it because they get the scope to do things and do them well.

Mr. R. F. Johnston: My question relates to the health service organizations and community health centres and it really relates to why they failed to have the same exponential growth in our system as the HMOs have had in parts of the United States. Part of that has been a reluctance of the professionals involved, and there are other reasons. Is part of it the design?

I think about the constraints put on the community health centres. They have to find a low-income group and a defined population with a defined need, and there are other kinds of restrictions on them. The HSOs have also had problems in getting off the ground and started. Why have they failed in comparison to the health maintenance organizations?

Dr. Mustard: I am not sure they have failed yet.

Mr. R. F. Johnston: They are very slow in developing; let me put it that way.

Dr. Mustard: But remember that the health maintenance organizations were slow in getting off the ground in the US. Remember that we are talking about--

Miss Stephenson: They were started in 1949.

Dr. Mustard: Yes. We are talking about a slow pattern of evolution.

Mr. R. F. Johnston: The one in Sault Ste. Marie has been trying for some years now too.

Dr. Mustard: You have to talk about it. It has to become part of the fabric of discussion in medical schools. It has to become part of your value system. The health service organizations are still regarded by some as a place where only the poor and other people go. It is not part of your culture yet.

Also, you have substantially to change the system. I always felt the weakness with the health service organizations is that they were not integrated with the acute care services, that is, the institutional sector was not part of it. If I were going to take it a step further, I would now pick up the desire of some boards--probably the Sunnybrook board, as I recall from talking with some of the people on it; it would be anxious to do this--to provide the complete package of care in the HMO framework. Maybe you need to design another term that you need to allow that kind of thing to evolve and really support it. You probably also need to find a way by which I as a consumer, within the principles of collectivity of our culture and public financing, am the person who is making decisions on which plan I am going to buy into.

I am simple-minded about this. I would then do it through a tax credit system; that is, if I had to pay \$500 to go into the plan, and automatically with a certain income I get a \$500 rebate--after all, I get it that way and it becomes a consumer purchase in the system rather than a government purchase. How it changes the government's policy is to set the public policy domain and the rules under which the system has to operate. Where it has to come in terms of tax base, it has to find a way to give me, if I do not have an adequate income, a voucher which I must use to buy into the plan of my choice.

I do not think that will be any more or less expensive than the present system, but it will certainly decentralize it and it will provide for innovation and for incentives for efficiency which you cannot put into the system any other way.

Mr. D. S. Cooke: Would the hospital budget be part of that?

Miss Stephenson: Therein lies one of the major problems in this jurisdiction relating to implementing something like the health maintenance organizations in the US. The hospitals are creatures of the provincial government and are public institutions which do not have a specific relationship with any group or even with a geographic area.

Mr. D. S. Cooke: One of the ideas I have heard is that we try it with Sault Ste. Marie and give the HMO its hospital budget for its roster of patients; it goes to the hospital and negotiates about 80 or 90 per cent of what it would normally use and it gets to keep the rest and increase services.

15:20

Dr. Mustard: Dr. Stephenson is quite correct about the hospital problem. I suggest you try to find those institutions that have the mindset to try to be innovative. You let them run with an opportunity. When you do that, it is important that the consumer be involved in the decision to be part of the plan. I am a firm believer that when I have to transfer my resource to you personally to provide me with care--and the resource may have been given to me by the government--for the simple reason that I am buying into yours versus another, I have an expectation of you.

The only way you are going to get the consumer back in the health care system is by giving the consumer a chance to kick you in the ass and to say, "If you do not provide me with what I want, I will go to the other one." In the present system, the consumers compete the other way.

The Minister of Health's time is spent dealing with the professionals. You should ask your Minister of Health, whether Liberal or Conservative, how many times he has sat down and met with the consumer as opposed to the Ontario Medical Association, the Ontario Hospital Association, etc.

Mr. D. S. Cooke: Why do they still have to have a voucher or an exchange of something to provide for that choice? If you have CHCs and HMOs and if I am allowed to belong to any agency--

Dr. Mustard: Psychologically, I would like to see myself just transferring it.

Mr. D. S. Cooke: That is what Darcy McKeough said about Ontario health insurance plan premiums, but every survey and every study has shown it does not have much--

Dr. Mustard: That is a bias of mine.

Miss Stephenson: It helps when people do not know they are being paid for them. Why should they have any feeling of participation?

Mr. D. S. Cooke: The way OHIP premiums are set up now, most people think the premiums pay for the entire health care budget. If anything, it has the opposite effect on the health care system right now.

Mr. Chairman: We are getting dangerously beyond these questions being supplementaries, and I do have a list.

Mr. D. S. Cooke: I have one final question, since I started this. At the present rate of change, which is very slow, towards any kind of substantial change in the system, will we really be able to get to the point where society accepts these kinds of fundamental changes, or will the crisis hit and something else happen and take over before these rational changes can be made in the system?

Dr. Mustard: One of your colleagues from the other party ran an interesting exercise when he was Minister of Health. If any of you had a window on that activity, which was trying to build a dialogue, understanding and some sense in all this, you realize the enormity of the task you are referring to.

The question is whether our government can effectively catalyse the discussion and the development of a consensus in our kind of society. If you cannot find a way to do it, then you are trapped by what evolves through advocates and everything else, without any kind of consensus arrangement developing in society. We really do have an adversarial system, at least as far as the press handles it.

The issues before us are such that we cannot solve them through the standard political process, which is an adversarial system. I mean that seriously. The pace of the change, the pressures and the demands are such that a system that evolved from a fairly stable, industrial-revolution, resource-base industry problem into the rapid change and the pressures we are into now means we have to become a lot more creative about ways to do things.

The universities have essentially failed to serve as instruments to facilitate this. They have not been able to fulfil that function in our

society. That is not damning them; they have just been unable to do it. The structure of our political system does not make it very good for doing it. Our media tend not to think items such as this are important to try to deal with; yet the problems are there.

Professional groupings such as the OMA and the OHA have been unable to create the dynamics for doing this. One of the challenges you therefore face in your role may be to think about whether you can follow up on what Mr. Grossman was trying to do, maybe using broader-based consensus machinery in the province to involve people, both professionals and consumers, in government and to try to look at ways in which you can recreate the system.

When you do that, you begin to understand the language I am using. You begin to become more familiar with the option. You begin to understand the challenges we all face. With that, it may become possible to create the kind of evolution you are talking about.

The HMO system moved to the United States because of a powerful group of advocates who kept hammering at it and pushing it, despite the system. The Americans have a lobby system; we do not have a lobby system that really works in our political structure. It was that lobbying system, which is a combination of professionals and academics, and I suspect some of the business community, that kept the pressure on the system.

This man, Enthoven, did stalwart service in the United States to push these ideas up into the policy machine and get them debated and discussed. Their system allowed this to evolve. Our problem is that we have a British system of government and all the things that go with that, which when you are into public financing creates powerful constraints to developing consensus for change. That is the issue you face.

It may be that to get the kind of movement you want you have to have a coherent policy of developing some kind of consensus dialogue machinery to allow the evolution to take place. I cannot take it any farther because it just sort of came to my mind when you raised the question. I do not know how to do it, but it has to be something different from what we have. You cannot do this through a policy that will not work. The professionals are going to have to change the polarizing against the minister. You will normally have the OMA down there striking in front of the Legislative Building; you will have the nurses, the hospital association and so on.

Mr. R. F. Johnston: What you need is a minister such as Mr. Elston, who is willing to sacrifice his career in the fight and who then becomes the victim of it all. That is the key.

Dr. Mustard: We can sacrifice a lot of you, but that does not solve the problem.

Mr. R. F. Johnston: Mr. Grossman wanted to go on to be Premier, so he could not do it. Mr. Elston obviously does not want to go anywhere in his political career, so we can sacrifice him in this.

Mr. Baetz: I agree that under the present health care system it is virtually impossible to apply the forces that operate and guide the market economy--in other words, where you make your investment and where you get your greatest return. You remarked earlier that the disconcerting thing is that more and more of our health care dollars seem to be going into expenditures

for the aged. I suppose a part of that is the demographics. There are more of us, but I guess a lot of it is also due to the fact that, as you were saying, more and more per capita is going into care for the aged.

I agree. I do not know how in the world we are going to get away from this unless we reach a crisis somewhere down the road. I wonder whether some changes are taking place in a socially acceptable way in that we are really rationing, which is sort of a dirty word, the health care dollar more and more as to palliative care. An example of this would be the growing interest in palliative care. We are beginning to say: "There is no point in spending a lot of money on this person to provide physician's services or highly technical services. What this person needs is care rather than cure."

Is this not at least an encouraging sign that in our very slow--maybe far too slow--subtle way we are beginning to recognize that we have to rationalize and ration more our expensive health care services? I do not know.

Dr. Mustard: Let me answer the first point. Ontario has within its system an enormous number of able physicians and nurses who understand the question you are referring to. Within the existing system, they do a great deal to tackle the issues and do it well. Their frustration is that the system is not a true system unless what they are doing benefits everybody, if you know what I mean. In other words, if you are a highly conscientious physician trying to do things efficiently, you are not in a system that provides any rewards or any recognition for that. You can even become penalized if you do it too well.

15:30

The second question about rationing really is a far more complicated question. It brings up a subject I have not talked about, but maybe we should spend a moment thinking about it in terms of the issues you face.

The information technology revolution will hit the health care system very hard. There are now instruments that can sample a drop of blood, your breath or your urine and give a virtually complete analysis. They cost less than \$10,000 and the cost will come down enormously. This changes radically the whole laboratory function in your health care system.

Programs have been developed using the simple aspects of artificial intelligence and ruled-based expert systems, with which you can take any disease entity and monitor a physician's intervention with that patient. They are set up in such a way that they can also be used to carry out clinical trials, looking at the effectiveness of diagnostic procedure or treatment procedure. On the other side, they become very powerful information packages, because you can actually monitor what the professional is doing to the individual or with the individual, the patient's course.

It would seem to me that if I were running a hospital or a health care delivery unit and I had 10,000 people signed up, I should know the health status of the population I am serving, I should know the range of services they are likely to want and I should know those services that are highly effective and those services that are expensive but not very effective.

I might decide in running this that we do not provide those expensive but ineffective services. You may call that rationing. I call it rationalization. That is different from rationing, but it is operating with the proper information system, on which you try to make rational decisions

against objective figures and facts. That capability is here now, but it is not really applied in our systems in Canada.

Hidden in what I have just said is that it is possible to determine what interventions truly do. For example, if you take coronary heart disease, coronary artery bypass surgery is truly effective only with certain kinds of patients, as opposed to medical treatment. It would seem to me that the governance of my care system should be such that I should not encourage the cardiovascular surgeon to engage in procedures for people for whom they are inappropriate, and you can do that. In other words, the question of effective care becomes very important.

Culturally that has really come into medicine only in the last 15 years. It has taken a while and it has not been strongly entrenched there. I forget what the figures were 10 years ago, but one large general hospital in this city did something like 1,500 barium enemas, which is the examination of the lower part of the bowels, before one was positive. Come on, let us face it. Surely you can become a lot more sophisticated. Maybe you have to do 100, but if you have to do 1,500, you can understand that governance and efficiency were not operating there.

If you apply that approach, true rationing may be unnecessary. True rationing is where you deliberately restrict a service that will increase the quality of life in an individual in terms of both easing pain and life expectancy, such as the situation in the United Kingdom with the kidney dialysis story.

But even in the UK there is a huge saving that could be made to tackle my question of effective care rationally given, which would even avoid some of the rationing they have in their society. That then supports my argument that you have to create a more decentralized system, which has legitimate market forces contained in it, to create professional incentives to give effective care efficiently and also to have a high degree of patient sensitivity in the process of doing it.

Mr. Baetz: So you are really quite pessimistic about the present system.

Dr. Mustard: I think the question was asked earlier. My answer is that the present system eventually will break down and you will end up with a two-tier system. It can only go that way; you will end up with a two-tier system. If you can afford it you will get it, and if you cannot afford it you will get shunted off into some situations that we may hide from ourselves or whatever we want to do. It depends on our value structure.

Miss Stephenson: We cannot create enough wealth to continue the kinds of directions we have been pursuing for the last 20 years. Something has to give. What we should be doing is using the knowledge we have been able to develop as a result of the introduction of technology in the collection of information and find the absolutes, if there are any absolutes--and I wonder sometimes whether they are really absolute, but they are relatively absolute--and then try to build something on the basis of that. Nobody is doing that at the moment. Federal governments do not do it. Provincial governments do not do it. Nobody seems to do it.

Mr. Baetz: I want to make another comment, not essentially relating to this but relating to your comments on the Swedes' fairly recent trend towards providing service through kin.

Dr. Mustard: That is not being done. That is an issue they are discussing.

Mr. Baetz: They are discussing that. Okay. But it is providing service through kin rather than through what?

Dr. Mustard: Through a friend.

Mr. Baetz: Yes. You were lending this to the health care system. In recent months, I have been more than ever convinced that we can also do the same thing, apply the same concept, in day care or for working mothers. In other words, instead of building more and more day care services, why not, through extended maternity leaves, benefits or whatever, encourage the mother financially--provide some financial incentives--to give that service to her own child at home for a two-year period or whatever?

Dr. Mustard: In the revolution of the change of jobs and income distribution in society that we face, with the radical changes that are taking place, those types of things have some very powerful opportunities in our society. They could be highly creative and very satisfying to people if we can create ways to do it.

Miss Stephenson: There is one aspect which all of you men cease to recall, however, when you start relating this type of activity for women; that is, when a woman is in a professional role, her professional development may be stultified if you insist that she spend her entire time in that role. You have to find a way to ensure that she is permitted growth in whatever professional role she has selected while she is assuming this task--which is terribly important for everyone and the most important in the world--or at least that she has the choice of deciding whether she is going to do it one way or another rather, than saying everybody has to do it the same way.

Mr. Baetz: You can also extend the benefits to the father. It can be for either parent.

Miss Stephenson: Or you could extend the benefits to a relative or to someone who has some capacity to do this who may not be a professional.

Interjection.

Mr. Chairman: We permit arguments here on a political basis but never on the basis of sex.

Miss Stephenson: Oh? When did we change?

Mr. Chairman: I have to indicate that Dr. Mustard is to be picked up here at 3:45 to be taken to the airport. Is that correct?

Dr. Mustard: I am going away. Yes.

Mr. Chairman: Is that all you have? Is that your last question?

Mr. Baetz: Yes.

Mr. Chairman: All right. I have Eddie Sargent to ask a question. Before he does, perhaps I could inquire whether any other members of the committee wish to question Dr. Mustard.

Mr. Sargent: I will be only a minute. I am very impressed with Dr. Mustard. I think we are lucky to have him in public service. It should be required hearing for every member of--

Miss Stephenson: When did he get into the public service? He has been in public service and every other type of service all his life.

Mr. Sargent: It should be a required practice of people in government to have dialogue with people such as Dr. Mustard, who knows what the hell he is talking about.

Dr. Mustard: That is a compliment.

Mr. Andrewes: And the inference is?

Mr. Sargent: I have been in the negative role so many years that it is good to hear somebody say something intelligent. I take it that you read Forbes magazine a lot. You sound as if you do.

Do you actually see members of the family on the public payroll?

Dr. Mustard: In this scheme? In terms of the support for people, no, I would not see it being on the public payroll.

Mr. Sargent: Or a friend, or whatever you just said.

Dr. Mustard: In whatever organization pays you, it becomes part of the policy of that state that your payment be kept up. Let me put it within the fabric of the Swedish society in debating this. One Swedish economist finally told me what the hell they really were. He said: "The Swedes nationalize only salaries; they never nationalize production. The Russians nationalize production." That is an interesting distinction. I learned this by talking with the blue-collar workers' union and the employers' group.

15:40

When they are going to do something such as this, there will be a long discussion. The discussion obviously includes ways in which to look at the economics of the distribution and who is paying what in the system. In their discussion, the employees will look at this as a wage transfer function. The employer may look at it as a cost, but he may also look at it as a cost that is cheaper than to have his taxes increased to provide it through a government system, if you follow what I mean. Ultimately in the dialogue, the employer will say: "All right. My employees regard this as just another part of our wage transfer function. It is an additional cost to me, but the additional cost saves me from having a taxation system. Besides, it comes back as a benefit to me because the system is healthier and more effective and ultimately I will benefit from it." They are kind of involved in the dialogue of what should take place.

My feeling about this is that it probably should be done through your instrument of employment continuing your income, rather than its becoming a state function. Obviously, it has to be done within a state policy and you have to look at how your state looks at how things are financed. This may require some rethinking about our financial institutions and how we look at financing. After all, remember, we are all products of resource-based culture and Toronto is almost the epitome of the resource-based mentality in Canada.

What do I mean by that? You are used to getting wealth by extracting and selling without adding value. Your financial and political institutions are all geared to that kind of society. The Swedish society is partly resource based but it also has an extensive amount of knowledge-based industry; that is, in new industries of the world, which it consciously went into. That kind of mindset, which I call the research and development culture in the modern world, tends to look at problems differently. It tends to approach the problems and the questions differently.

For example, Volvo has an arrangement with its blue-collar workers' union that there will never be any resistance to increased productivity providing the wage transfer or wealth transfer function is maintained. With everything General Motors has done in the United States, it is still struggling to equal the productivity of Volvo. It is still wrestling with how to keep up with those people.

If you are going to try to do this--and I hate to say this to you because it is tough to do and I am not there myself yet--I think you have to start trying to approach it within the context of the kind of world in which we are operating and in which we will increasingly have to operate, which is different from the resource-based economy that we and our institutions have grown up with. That means you have to look at financial questions, financing, etc. It is a different perspective than we have had in the past.

Having said that, I would plead with you to look at this as a transfer function associated with the source of employment, rather than the government becoming directly involved.

Mr. Sargent: Okay. I have one more question. You say robotics are going to create a great surplus of jobs and there will be a lot of people unemployed. Did you say we could offset that by making a special pool of money that would transfer--I lost you.

Mr. Chairman: Redefine jobs.

Dr. Mustard: Let me try to get you to think about this in a context that may make it easier. It is not an easy thing to come to grips with.

If you look at human existence, the species homo sapiens has been on this planet for about 100,000 years, based on scientific data. If you collapse that down into one calendar year, you get some interesting time perspectives. We were hunters and gatherers until the middle of November. Hunters and gatherers do not have a work ethic.

Mr. Sargent: Say that again.

Dr. Mustard: We were hunters and gatherers until the middle of November and there are still hunters-and-gatherers societies on the planet. Those people had enormous freedom in what individuals did. They were fairly collective societies, but basically they had no work ethic. They had to find food and shelter, but basically they did all right. Historically, any time they came up against an agricultural society, they stayed away from it. They hated the characteristics of an agricultural society, which started around the middle of November.

The agricultural society produced large amounts of food, which allowed 20 or 30 people on a farm to keep one person in a town. The energy to run those societies was essentially animal, wind and water. The animals include

humans, so you had a very hierarchical society with a hell of slave labour in it. That was not a very satisfactory working condition for most people either.

One day before midnight, about 200 years ago, we learned how to harness fossil fuels. That was the industrial revolution. The wealth generation work concept that you and I are familiar with is of that period, which is one day in my calendar.

If you think this through, what did the industrial revolution do? It really generated wealth. We eventually found ways to distribute that wealth, to vastly improve the quality of our societies. Work was associated with that, and we used the work function with the industries as initial distribution. As we became more productive, however, we started to cut the jobs out of agriculture and manufacturing industries and expanded our service industries. It has been a wealth transfer function, creating new activities.

What you are faced with now is a substitution of machine intelligence for human intelligence in almost every job, which will probably take place within 25 years. With that you will no longer have a labour market that you and I associate with the General Motors plant, etc., to transfer wealth through jobs. However, you will be able to generate wealth, because you will still improve things.

Given that, you have to tackle how you distribute wealth in society, how you get out there. Second, you have to look at what I no longer call jobs, the range of human activities that are possible in the society, because I am going back to the hunters and gatherers. In other words, you almost come to the freedom of the hunter and gatherer, but you will have housing and food and do not have to hunt for it; so you can say, "Well, we can watch television and drink beer."

That is a pile of crap--pardon my English. If you look at what young people are doing today, if you go to the Banff School of Fine Arts, there is a wide range of things that go on there. It is growing exponentially and young people are going there. What does it do? It gives people the opportunity to do things, to express themselves and create things.

Miss Stephenson: Freedom is what it is called.

Dr. Mustard: Go up to Durham, Ontario, which is close to where we have a small piece of land. There is an annual wood show now. It has been going for four or five years and it keeps growing. There are all kinds of people up there creating things out of wood, which they will sell to you or give to you. They are doing things they want to do. That is what I mean by the kind of change that is taking place.

Within that framework, if you look at your service industry sector, you have service industries related to communications and transportation. You have service industries in the retail and wholesale trades and in the financial institutions. They are probably not going to grow a hell of a lot, because they are going to be impacted by automation. You have the human or social services sector, which is going to grow exponentially.

You also have the personal services, entertainment and recreation. Those are the enormous fields of opportunity for the future. When you see it that way, the questions you are posing about health and social services have to be seen within the context of the change in the nature and distribution of work and the opportunity that goes with this if you can generate and distribute your wealth.

Mr. Sargent: You say to generate the wealth and distribute it. How do you distribute it?

Dr. Mustard: I said I cannot solve that problem. Nobody has solved that yet. That is the thing you have to start thinking through.

Mr. D. S. Cooke: You will have to keep some of it in Canada too.

Dr. Mustard: There are ways in which you can look at how you do that. The Swedes obviously have strategies for doing it, and it is interesting to think a bit about it. ASEA, Pharmacia and Volvo are multinationals that operate out of Sweden. Look at Canada's biggest high-tech enterprise, Bell Canada Enterprises Inc., and look at its operation in contrast to ASEA and Ericsson. It is sliding out of Canada, and you have to ask yourself why.

Maybe it is something that cannot be done and maybe it is something within the public policy framework of our country that is flawed.

Mr. Chairman: On the question of our industries moving out of Canada as well, they believe they are being overtaxed through the greater need by government for money to fund the programs you are speaking of.

Dr. Mustard: It is more complicated than that.

Mr. Chairman: In a sense, that is part of it.

Dr. Mustard: I do not know if that helped to answer your question.

Mr. Sargent: Yes, you did very well. Thank you.

Dr. Mustard: If you see it in that context. I could be accused of stirring the pot prematurely, but I do not think I am. I think the issues are before us. They are here now.

Just to let you understand the magnitude of the pace of the change--for reasons which Dr. Stephenson knows; I do not suppose any of the rest of you are aware of it--the institute I am involved in did a report under the leadership of James Ham, the former president of the University of Toronto, on Canada's participation in the United States space station.

The United States space station is not an instrument to let the Americans command space. It is partly that, but the Russians are there as well. It is a deliberate United States government science and technology policy. There is full government intervention. I do not think I have to tell you how the United States uses the marketplace. There is full government under Mr. Reagan. It is designed to allow the Americans to beat the Japanese in the creation of advanced automation robotics.

15:50

If you read the US Congress documents and the July 25 House of Representatives document on this, they are demanding that the National Aeronautics and Space Administration's first unit that goes up on that space station have the first stage of its telerobotics device. A telerobotics device is a sophisticated robot. It is not a dumb robot. Telerobotics means there are still humans in control, but Congress has mandated that by year 2010 they operate without humans in control.

Canada has a little piece of that action and the Americans sense we have it, so they are now trying to push us aside. The Japanese are putting that up in their unit. Have you heard of the Japanese fifth-generation computer project? The US space station bypasses that completely, because the computing capability necessary to achieve what they want in that space station requires a revolution greater than what the Japanese are proposing to do. It is simply a direct US government market pull created under a US public policy of its government to radically change its industries.

That competition is there before us. In 1993, when the units go up on the station, you can bet your bottom dollar that those units will be going out to people who do other things in this society during that decade. I do not think I am being too premature in arguing that the pace of change you are facing is really very real and that you will see substantial changes in the next 14 years.

Mr. Sargent: Thank you doctor.

Mr. Chairman: Thank you very much, Dr. Mustard. Your presentation and the answers you gave were very thought-provoking. I will keep these in mind as we go through this process.

Mr. D. S. Cooke: A faceless process.

Miss Stephenson: Why cannot we be visionary about this process instead of honing in on tiny little details that really are not going to make one bit of difference 10 years from now? Honestly.

Dr. Mustard: Yes. Justify my expenditure.

Mr. Chairman: Thank you very much, Dr. Mustard. We wish you a safe trip, wherever you are going.

Miss Stephenson: You are not going to Tromso?

Dr. Mustard: No, no.

This is Ted Marmor's article on nonprofit and for-profit organizations, which is a very fair analysis of the US scene. It is not a public document, but would you like make a copy of it for your files?

Mr. Chairman: I would like to, but I was advised by the clerk that we already have that.

Miss Stephenson: No. It was the other one. We do not have that. It was a personal communication.

Dr. Mustard: As long as you will swear that you will send it back.

Miss Stephenson: I will promise we will get it back to you.

Mr. Chairman: Thank you very much, Dr. Mustard.

Dr. Mustard: Good luck in your endeavours.

Mr. Chairman: We have a couple of housekeeping items to do before we leave. As you know, we have asked the whips to approve additional time if

necessary. I hope we are going to make that decision after we have had an opportunity to meet with our consultants. We are going to meet with them tomorrow and Friday.

If we are going to use that week of September 15, I understand there are some conflicts, one of them of absolutely monumental proportions. There is a very special event that is held, and it is absolutely necessary that certain people attend that event. How does it go, Mr. Reycraft? What are the dates that we are to go with? Is it Wednesday, Thursday and Friday of that week, or is it Monday, Tuesday, Wednesday and Thursday?

Mr. Reycraft: I knew about Wednesday and Thursday. I did not know about Monday, but there is no problem with Monday.

Mr. Chairman: Tuesday is the bad day. Is that correct?

Mr. Reycraft: It is the day on which we have a number of members away.

Mr. D. S. Cooke: I would like to see how much we accomplish in the next couple of days.

Mr. Chairman: We can do that but that decision should be made tomorrow or Friday. I will not be here.

Mr. D. S. Cooke: I will not be here on Friday, but if the committee is to meet during the week of September 15, there are certain days I am away and there are certain days others will be away. Whoever can be here will have to be here. We will just have to do our best.

Mr. Andrewes: What is this occasion of monumental importance? Are the Liberals having a conference or something?

Mr. Chairman: No. It is the ploughing match.

Miss Stephenson: I thought it was going to be the day of the cabinet shuffle.

Mr. Chairman: It is a matter of great importance.

Mr. D. S. Cooke: So one person is away? Do you have to go to the ploughing match?

Mr. Chairman: It was in 1985, but I did not get to go. Normally, in these committees there is not continuity of the people who attend, but I think it may be of some importance that there be some degree of continuity. I do not know how the committee feels about that.

Mr. Baetz: Only one member from the committee would be missing?

Mr. Reycraft: Mr. Poirier would be affected as well.

Mr. D. S. Cooke: If there is one person away one afternoon, then he has to substitute. We are not taking votes or anything. We are going to be together for the next year. If you miss one day, you can read Hansard.

Mr. Reycraft: I think there is a problem in staffing the other committees as well. It is the number of committees that would be meeting that day if we met.

Mr. Chairman: Why do we not leave it then?

Miss Stephenson: The purpose of the meeting with Stoddart and company, at least tomorrow and Friday, is to determine whether what they are suggesting about what the direction and the scope of our examination should be is appropriate. If we can determine that on Thursday and Friday of this week--

Mr. Chairman: They do not need--

Miss Stephenson: I thought we said we might give them a couple of weeks to produce something.

Mr. Chairman: The plan.

Miss Stephenson: No. We have given them the couple of weeks. That is what this is, tomorrow and Friday.

Mr. Chairman: That is right. The plan is supposed to be here tomorrow.

Miss Stephenson: We did not have any plans for them after that. They will not have completed their area of activity by September 15, and the only other thing we could do at that point would be to have further interviews with people. Are there other ministries we have to hear from or are there other people whom we believe we have to talk to right at the moment?

Mr. D. S. Cooke: I thought that after they presented the plan--and we will debate the plan and change it, I assume--they would take that plan and the data and pull together our interim report, which will spell out what we are going to do.

Miss Stephenson: Our interim report, which provides the direction for us.

Clerk of the Committee: The committee's recommendation was that they come together with an outline, that we put it together with the data from the ministries and make it formulate the interim report. The reason you wanted to sit down on the week of September 15 was to put that together.

Miss Stephenson: To put the interim report together.

Mr. D. S. Cooke: The data the ministries have supplied to us are helpful, but I assume they are going to have to spend a lot of time pulling more data together and making it more concise than 400 pages. There has been a lot of stuff and, hell, it is really hard data. We cannot consider an interim report on September 15. I assumed we would be considering an interim at some point in late October or early November, as most select committees do, when something is written up for us.

Miss Stephenson: We are a select committee and we are not permitted to sit--

Mr. D. S. Cooke: They always get permission to sit from the House.

Miss Stephenson: --in order to produce reports.

Mr. Chairman: We will leave that issue until tomorrow or perhaps Friday.

Mr. Sargent: When do we go to Australia?

The committee adjourned at 3:58 p.m.

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SELECT COMMITTEE ON HEALTH

COMMERCIALIZATION OF HUMAN SERVICES

THURSDAY, AUGUST 28, 1986

Morning Sitting

SELECT COMMITTEE ON HEALTH

CHAIRMAN: Callahan, R. V. (Brampton L)
Andrewes, P. W. (Lincoln PC)
Baetz, R. C. (Ottawa West PC)
Cooke, D. S. (Windsor-Riverside NDP)
Johnston, R. F. (Scarborough West NDP)
Poirier, J. (Prescott-Russell L)
Polsinelli, C. (Yorkview L)
Reycraft, D. R. (Middlesex L)
Sargent, E. C. (Grey-Bruce L)
Stephenson, B. M. (York Mills PC)
Turner, J. M. (Peterborough PC)

Substitution:

Wiseman, D. J. (Lanark PC) for Mr. Turner

Clerk: Deller, D.

Staff:

Fooks, C., Research Officer, Legislative Research Service

Witnesses:

Stoddart, Dr. G. L., Associate Professor, Department of Clinical
Epidemiology and Biostatistics, and Associate Member, Department of
Economics, McMaster University
Labelle, R., Lecturer, Department of Clinical Epidemiology and
Biostatistics, McMaster University

LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON HEALTH

August 28, 1986

The committee met at 10:15 in committee room 2.

COMMERCIALIZATION OF HUMAN SERVICES
(continued)

The Vice-Chairman: We can get the ball rolling after a 15-minute delay, now that we have a quorum and now that everybody has been given an appointment before 10:30 this morning to whatever boards, agencies and commissions all of you chose. Welcome to our committee this morning. The day is yours to tell us how you will help us solve this most interesting mandate.

GREG L. STODDART AND ROBERTA LABELLE, McMASTER UNIVERSITY

Dr. Stoddart: On behalf of Roberta Labelle and myself, I would like to start by saying that we are looking forward to working with the committee. We are pleased you think there is a role for our expertise. We met with the steering committee but we are not familiar with all the members of the committee who are here. At the steering committee meeting, we talked about a role for research advisers or architects of the research endeavour to provide input to the committee's interim report and final report.

This is very much what we have gone away and done in the interim. We have prepared a proposal on how to deal with the research side of the enterprise the committee is involved in. We have produced various pieces of information for the interim and final reports that we will review in some detail today. We have a handout to pass out in a moment.

In parts of the handout, this research plan is indicated as preliminary. It is not so much because we do not know what we want to do. It is because on some matters we are not entirely sure what you would like to do. I hope we can finish going through the plan and finalizing it in a day because we would like to get on with some other matters with Cathy Fooks, for whom we have some plans. If that can be finalized today, we would like to meet tomorrow morning and continue to get some of the research endeavour mobilized quickly. That is our objective.

In the past couple of weeks, aside from giving some thought as to how best to go about the research plan, we have, as promised, prepared a small, annotated background reading list for the committee and we have had some initial contacts with various people we think might be able to provide input, expert commentary and presentations at later stages. We do not have a list of those individuals today. That is something that properly would be finalized after the research plan is decided on. We have also begun the literature assembly that in the course of this plan will probably be contracted out to some expert for synthesis.

We indicated at the steering committee meeting that, subject to our university commitments, we could probably commit ourselves only to being the advisers and architects and to monitoring some things. We would be most willing, as part of the plan, to help the committee specify or write the performance specs for certain pieces of research that need to be contracted

out. These pieces would be done by outside people with us monitoring it on behalf of the committee. That is the overall atmosphere in which we hope to work with the committee. Why do we not get going?

We have some screens and charts. I do not know whether we will need them. We will draw on them from time to time. I think the best way to proceed, the way I hope we will proceed to work with the committee over the next year, is that when people have issues, questions or comments they should shout. We would like to run it quite informally. We want to develop some sort of relationship whereby when you have something on your mind that relates to the research, we discuss it. The best way for us to serve the committee is if we understand exactly what you want to accomplish.

10:20

The material we referred to from the background readings is on the right-hand side of your folder. We will leave that to you. It is annotated. We will be happy to discuss any of it with any of you at any time. It gives a good flavour of some of the literature and the variety of literature we anticipate someone having to synthesize and review to produce the first part of what eventually will be the final report which covers the experience and the lessons in other jurisdictions. We think the views in the literature we will discuss will also produce some very important directions for some of the questioning, invitations to experts and examination of contributed briefs during the public hearings stage.

The material in the left-hand part of the folder is the subject of today's meeting. The agenda we are proposing is that we will go through the research outline, with interruptions, discussion and so on. I will work through certain parts of it with the committee; Ms. Labelle will work through other parts.

Second, we have identified four or five major issues the committee needs to think and talk about and give us some direction on before the research plan is finalized. We have identified those on a separate page. There may be other aspects or questions, and there are some administrative arrangements we would like to clear up with the committee about certain roles and how things will be done. Then we have some suggestions we will go through for the first steps to mobilize some of the research activities. If we can finalize the plan, or 99 per cent of the plan or whatever proportion we can today, Ms. Labelle and I are quite willing to begin work on it tomorrow morning with people here.

We have called this planning document 1 because we anticipate there will be some changes and revisions, but we do not envision planning documents 4, 5, 6 or 7. We are hoping that planning document 2 will be the final one.

We have a summary of the plan. We are proposing that the research activities be viewed in three phases. We describe each of those. We have presented a preliminary critical path. As I say, there are some specific issues on which we want clarification, and we have a preliminary budget which, in the course of the day, once we have a better idea of what the committee wants to do on certain items, could be finalized.

That is what we plan to do today. Does anyone have any questions about the process, the agenda or what we are likely to cover or not cover today?

Mr. R. F. Johnston: It is a good way to organize it. I hope you are right about our being able to do it on Monday. As with all things with the committee, the key is to start and see where we end up.

Interjections.

Mr. R. F. Johnston: Let us go.

Dr. Stoddart: Let me take you through the summary.

We are not going to do songs and dances on the screen for the summary. We would like to work through it on a line-by-line basis. Basically, we would like to work through the whole document on a line-by-line basis. I remember some time ago, I guess it was in the select committee on health care costs and financing, there was some discussion about being presented with slides that had three words written large, in Bill Cosby-like block letters, to present things to a committee such as this.

I will go through the summary and the general outline. Roberta, will you take phase 1 and phase 2?

Ms. Labelle: Yes.

Dr. Stoddart: Okay. We are proposing that the research activities be broken into three phases, and the words with which these can be labelled are "descriptive," "analytic" and "normative," or a recommendations phase.

The descriptive phase would run from tomorrow morning until December. Primarily in this phase, as is written in the second paragraph of the summary, we would like to get the inventory of the commercial sector accomplished, the description of the extent of commercialization, the regulations governing provision and matters such as that, without trying at that stage to do any evaluation of the performance of the commercial for-profit sector, but just getting a handle on the size, the dimensions of it and so on.

In the course of doing that, some other research activities will be going on coincidentally. By about the end of November we hope that, by contracting out the large part of the data collection for the inventory, and with discussions that we hope will go on with at least the steering committee, if not the committee, during the fall, in addition to the inventory it will be possible to have already identified some key policy questions and to be able to include at the end of the interim report a synopsis of issues that are going to be concentrated on during the public hearings and during the evaluation phase of the research, and also plans for the rest of the research activity.

Phase 2 would be January to May 1987. What we want to focus on during this phase, as you can read in the third paragraph, is evaluating some of the claims and counterclaims about the performance of the commercial sector. In that phase, which I presume will be the phase of public hearings, the research activities will be primarily the completion of a synthesis of the existing literature and also the commissioning, as necessary, of background papers or commentaries by experts dealing, we hope, with very specific questions on what is known about this or that question, not general polemics about the sectors. The committee, in the course of today, will have to assist us a bit in shaping some of those specific questions. However, there will be occasions in the fall when we can do that too.

The results of phase 2 of the research should then produce a large chunk of the final report in the form of a final literature review and synthesis, and the results of phase 2 should also produce a grid. What we have in mind here--at least the concept is there, if not the content--is putting key policy

issues, which are specific questions, across the top. What we have in mind on the rows are sources of information that the committee has gleaned. Public hearings are one source; expert testimony is another source; what we synthesize from the literature is another source; things that have come out of the inventory are another source, and there may be a variety of sources.

10:30

We hope that as the phase 2 activities go on, Cathy, with our assistance, can keep track of what we have learned from various sources on each of these major policy issues in a very summary form. It seems to us that if the committee is to do this with the kind of budget we have envisioned, we will not have the luxury on the research side of duplicating, as it were; obtaining the answers to most of the questions from each source. We may want to focus and concentrate on what we think the most efficient sources are to get the information.

I do not anticipate there will be entries in every cell, and we may at times want to have a research meeting with the committee to suggest that you concentrate on this or that area in a certain public hearing because that is an area where we are not getting information in any other way.

That is the concept of what will come out of phase 2 and it will be presented by Cathy, Roberta and myself at the beginning of phase 3 to the committee for its deliberations during the final report-writing stage. We have put that in the preliminary budget, but we will work through that in some detail. That is the overview. We are going to go into each of the phases to describe them in more detail.

Before I turn over the detailed reviewing to Roberta, I want to say a couple of words about the architecture of the research. We see the research activities as being complimentary to what the committee will do on its own and will go ahead with. The objectives are very clear from our point of view. The research activities will inform the committee regarding the extent of commercialization and the characteristics of the commercial sector. That should be done this fall. We will assist the committee on focusing on key issues. I am sure you have many specific questions you would be happy to write across the top of that chart.

The research will inform the committee of evidence. This includes an assessment of its validity and its quality. We expect that the quality of the evidence that can be obtained within the constraints of a small budget will be variable and may, in some cases, be spotty. We would like to make sure that the committee is aware of the quality of evidence it is getting and that the evidence relates to key performance issues.

With your direction, the research will assist you in identifying policy alternatives, discussing advantages, disadvantages and potential impact on performance from what we know about the research findings.

When we talked to the steering committee, many comments were made about what the real purpose of the committee was. I believe the chairman had a very broad view of the committee's goal, which was to improve the bang for the buck in the health care system. That is the sort of thing 10-year research programs or perhaps even task forces are built on, but we do not think that particular goal is the one that should guide the detailed research activities of the committee.

What we have tried to do in the next section of the outline on page 3 is to suggest that the committee could view its own activities at three levels. A very narrow view of the committee would be to look at the extent and performance of private for-profit sector activity alone, without any consideration of its juxtaposition to public sector activity, private not-for-profit activity or anything such as that. That would be the narrowest interpretation of the terms of reference.

The second level at which the committee could view its activities would be an examination of the private for-profit sector but only in comparison with, or set in context of, private not-for-profit activities and public activities. The second level is important and is perhaps a more realistic interpretation of the terms of reference.

The third level is a potentially huge endeavour. What we suggest is that we do not lose sight of the third level but that we do not commission any research activities specifically designed to investigate issues at the third level--maybe one background paper or one commentary--but we are not going out to commission large-scale research to come up with a corporate plan for the Ministry of Health or the Ministry of Community and Social Services.

This third level would say the whole issue of the public-private mix is only one issue. It may not even be the most important issue in terms of improving the performance of the health care sector. There may be a variety of other things that could be done within the public sector or there may be other issues, such as manpower planning, which would divorce the significance of the issue of the private-public mix.

At the third level, we are suggesting no research be commissioned to determine that, but that both the committee and the research staff keep that in mind. During phase 3, those kinds of issues should receive general discussion. Certainly, any of the literature relevant to that assessment should be introduced.

Basically, we believe the research we are describing, and that Roberta is now going to go through in detail, concentrates at levels 1 and 2 and not level 3. That is the overview.

Ms. Labelle: I would like to take a few minutes to go through in more detail the overview of the phases, phases 1 and 2 in particular, to give you an idea of the types of tasks we had in mind and the products that would result from the research. As Greg mentioned, phase 1 is intended to provide an overview of the extent and types of commercial activities in the health and human sector fields.

The first thing that has to be done before any data are collected is to define what the committee means by the term "commercialization," because it has various interpretations and various settings. Before we can go out and begin to think about gathering data, we have to be fairly specific about the type of information we want.

Until submission of the interim report, which we assume will be in December, the remainder of the period will be devoted to gathering data and approaching various agencies, private corporations and people in the ministries to get the types of information that will be of use in subsequent analysis in phases 2 and 3. This information will also be useful in providing us with an estimate of the extent of the commercial activities.

The terms of reference were fairly specific in some ways about the types of things you wanted to see done and the types of data you wanted collected. What we got from the terms of reference were four broad categories of data that we think are essential to get. The first effort will go towards approaching people, individuals and agencies about getting this information. They are the four points listed on page 4.

The first is total expenditures broken down on a public-private basis. As part of that, as specified in the terms of reference, the sources of the funding for those expenditures should be determined, if possible. The second is the total volume of services. The expenditures are put in real or output terms, such as number of patients served or number of licensed beds, again by type of service. Also needed are a description of the actual types of care provided by the private, commercial or public sectors.

Finally, we would like, and you have asked for, a review of the existing legislation and proposed amendments to that legislation governing the provision of care. There are a number of other related pieces of information we would like to get at the same time. They are listed on page 4. Those data were all explicitly set out as things that should be gathered, according to the terms of reference.

There is a whole subset of data that was not explicitly referred to in the terms of reference that we thought would be very important to get, if possible, because it would certainly facilitate the analysis and interpretation of the components of the existing sector. They are the points on page 5, the first being sector-specific costs. That includes the input requirements typically associated with costs: staffing, capital and those sorts of things.

10:40

Another would be the characteristics of the patients served. That will be important when the committee addresses questions of accessibility, equity and the provision of services. Finally, information on charges or payments incurred by patients is important because, although we might have a handle on total expenditures, it is essential to know how much of that is incurred specifically by the patients. Those data should be gathered, not only for the current year but also for as many years back as reliable data exist, so that analysis of the trends in service provision can be conducted.

We would take data, such as expenditure data, and adjust them to a per population basis, therefore removing the effects of population growth. We would adjust it for age and sex differences, therefore removing the effects of change in the demographic characteristics of the population, and then get a good handle on what the actual trends are or seem to be in the system.

I suspect we will have problems going back very far. Reliable data sometimes do not exist in the present and are even more difficult to obtain for the past, but this would be an ideal of what we would like to do. The results of the data collection synthesis will, we hope, form the basis of the interim report. The interim report should analyse and provide an overview of the extent and types of commercialization and lay out the agenda for the subsequent research in phases 2 and 3. That would be completed by December, if our understanding of the deadlines is correct.

The Vice-Chairman: Before we proceed to phase 2, it might be interesting if Ms. Fooks could comment on your proposal for research to

compare it with what may be already available, to avoid duplication, and to talk about it while it is still fresh in our minds.

Ms. Fooks: A lot of the information in these two black binders was supplied to us by the ministries over the past two days. I do not think we will have to spend a lot of time on data collection.

Ms. Labelle: We were not aware you were meeting with the ministries and we do not know the types of data you have collected. We have approached the ministries on other occasions.

Ms. Fooks: We have a lot of the things on your list, such as expenditures, types of programs, legislation and number of beds, or it is being supplied.

Ms. Labelle: That is great. I guess most of this does exist, and that considerably facilitates the task. It is only a matter of putting it together.

Dr. Stoddart: Can I make a couple of comments? It is unfortunate we were not aware the ministries were going to present, because there may have been some questions we could have asked which would have resolved some of the things that now we will have to talk about with Ms. Fooks. That leads to the question, can we go back to them?

The Vice-Chairman: Of course.

Dr. Stoddart: Has a liaison person from each of the ministries been identified?

The Vice-Chairman: Yes.

Dr. Stoddart: Are they prepared to appear again?

The Vice-Chairman: Yes.

Dr. Stoddart: Have there been any other presentations? We are wondering how they would fit into the research plan.

Mr. R. F. Johnston: Dr. Mustard has been here.

Dr. Stoddart: Can we get copies of anything that was presented?

Clerk of the Committee: Yes.

Dr. Stoddart: Can we get copies of the binders?

Clerk of the Committee: Yes.

Dr. Stoddart: Thank you.

Mr. R. F. Johnston: This would be a good time to break and have some questions before we get into phase 2. Although I agree with Ms. Fooks that a lot of this stuff is in the binders we have, I am not exactly pleased with the format of the one from the Ministry of Health in particular. I like the format of the one from the Ministry of Community and Social Services, but I am not happy with the information in terms of the extent of the specific information on numbers of beds, amounts of money and that kind of thing.

Besides gleaning this information from the ministries in terms of hard data, how else would we get information to confirm the actual experience out there? Data from a ministry in terms of the operation of beds--or looking at a more controversial area, accountability--might be quite different from the experience of groups operating in the field such as private group home managers and how they have been expected to operate. For example, we have learned that they do not have financial accountability in hard terms from the ministry, but there might be certain kinds of pressure put on by the ministry because of their budgets to be able to determine that there was a good expenditure of funds and that kind of thing.

I am not clear that the information we will get from the ministries will specifically give the committee a clear idea of the reality out there in the field and that in terms of what you are talking about over the fall in the development of data, we should somehow be going to other sources in the Health and Community and Social Services fields to get their statistics on some of these matters to see whether these things necessarily jibe totally. They come from different perspectives. Is that possible?

Ms. Labelle: I think it is essential, and not only from other public sector agencies but from private sector agencies as well. Although a large part of the task is actually getting the data, an even more formidable exercise is to try to reconcile the various data we get from sources. The data we have worked with from the Ministry of Health and the Ministry of Community and Social Services do not agree. The two ministries do not come up with the same estimates of the number of beds in certain areas. One of the reasons Dr Stoddart was asking whether we could go back to the ministries was that unless you start digging and probing as to why these differences exist and why certain data are not available, you cannot get a handle on what is going on. We certainly would not limit the data gathering to Health and Community and Social Services.

Mr. R. F. Johnston: Two things come from what we got before. First, we need a systematic approach in receiving information that is the same for the two ministries so that we can do the cross-referencing. I do not think what we have received allows us to do that at this point. Second, we need this other source of information as well, and it will take us a lot of time. Getting everything to match and be as coherent as possible by December will be a major feat.

I have a question for the committee about something we will have to deal with. From this suggestion, we are presuming there will be an interim report prior to holding public hearings in January. Select committees do not have the right to sit when the House is sitting. When will we deal with the recommendations that are to be produced in December and prepare a report before we actually do it in January?

Mr. D. S. Cooke: We could get permission to sit to consider a report.

Mr. R. F. Johnston: That is what we will have to do.

Mr. Andrewes: We have done it in the past. My only experience was with the select committee on energy. On about five occasions we sought permission to sit to consider a report.

Mr. D. S. Cooke: One thing that will be necessary will be to try to get the interim report during the space between the time we publish the interim report and the time we start public hearings so that interested groups

have enough time to analyse the data and the report and prepare their data and information so they can make good submissions to the committee.

Mr. R. F. Johnston: What that means to me and what I am hearing is that, given all the problems we know there always are at the end of this session in terms of time constraints on all committees and the piling up of estimates and all that stuff, we will be aiming to have some discussion of this by early December so that something can be published over the December-January period. We would not hold hearings until the February part of the next break. Is that the general flow we would be aiming for?

Mr. D. S. Cooke: Even that is tight.

Mr. R. F. Johnston: It is tight but we are not able to meet for public hearings when the House comes back in March, if that is when it comes back.

Dr. Stoddart: This is exactly what we want to do. It raises a whole series of things that I would like to say. I want to come back to Mr. Johnston's point. When you said that even though the data are presented by the ministries they do not convey the real picture, there are two senses of that we might want to pick up on. One is that the statistics may not be reliable or valid or they may be too aggregate. In other words, if you went through another data source of data bank records, you might get different numbers. That is what Roberta was discussing. That is a real problem. We estimate it will be close to a full-time job for Cathy just on the inventory, working with us and whomever we get as a private contractor to do the legwork on getting the numbers.

10:50

The other sense that comes through there is that the numbers, regardless of whether they are accurate, do not convey the environment in which these agencies and firms operate. That, in turn, has two potential interpretations. One is that there is a whole series of descriptive things of which the numbers do not give a picture. That is important for phase 1. If there are descriptive issues that are not covered in the terms of reference or if there are dimensions that people want information on, that is something that has to come out in discussions and consultation between the research staff and the committee over the fall.

The second thing there was the issue of performance. You are saying the mechanisms for accountability do not work or they work too well. That is the sort of thing we want to get into in phase 2.

Some of this data collection that goes on in the fall will not necessarily be reported in the interim report because it is not descriptive. It is not like taking a picture out there. It is actually making some assessments that this is working well and this is working poorly. We would like to leave those judgements and investigations to phase 2 of the research, even though we might have received some information in phase 1. The implication is that the interim report will be a descriptive report so that people can come to public hearings or contribute briefs saying: "You have missed something. You guys have it wrong. There is another dimension here. I do not agree with your numbers."

The interim report is not meant to be permanent for the record in any sense, but to have a chance for a mid-course correction or to pick up some

omissions, to find out whether the committee is on the right track in terms of what people out there feel. We should see it as a success if the interim report prompts people to come and say, "Here is what you really need to think about now for a final report."

The last thing is that we really have very little idea--and we will discuss this later--of what your arrangements are or what arrangements or promises have been made to any firms about getting some contract to do data collection. We understand there is some opinion that Research Innovations is a firm we should talk to about doing this work, but we can come back to that. Certainly, we see that the legwork and actually getting the numbers from these other agencies will be something that neither we nor Cathy can be doing. That is a contract we will have to let, write the specifications for and monitor. I do not know whether that is helpful, but that is how we see it.

Mr. Andrewes: When we discussed this with the steering committee, you asked us to focus our thinking on two aspects. One was quality of care and the other was the cost. I have somewhat the same concern Richard had. I wonder whether an analysis of the existing data will give us that type of direction.

Ms. Labelle: It is difficult to say right now without actually going out and getting the data. I suspect that it will be much more successful on the cost side than on the quality of care side, not because people are not concerned with quality of care, but right now the measures of quality that exist are fairly crude. There are efforts going on across the province, and some research is being done on quality of care. We would want to get the results of that research. Even though it might not have province-wide implications, we could at least identify what the state of knowledge was on that aspect right now.

We are getting into phase 2 a bit, and I will come back to this. A lot of those issues can also be addressed by looking at evidence from other jurisdictions. In a big chunk of the second phase, we will be reviewing what has happened in those two areas, specifically in other provinces, the US and Europe.

Dr. Stoddart: If we are talking about costs in precise dollars and cents, an actual amount, \$253.55 a day, it is pretty unlikely that that level of precision will be possible. The real issues are going to be relative costs, orders of magnitude in this model of provision and that model of provision. We may be more successful in getting a good handle on that, but I do not think anyone should expect that we will be able to pin the costs down very tightly, at least not without commissioning a specific costing study, which we do not envision doing, although we are certainly willing to talk about those sorts of things. We are talking about collecting data rather than commissioning a research project to determine the actual costs in this model. Maybe we need to talk a little bit about whether the committee wants to do new research on that.

Mr. Andrewes: We are all treading water to some degree at this stage of the game. My view of the interim report is that we should start off with a broad range of issues. We have a bookful from the Ministry of Health and one from the Ministry of Community and Social Services. There are probably more, but at some point we are going to need to focus our efforts.

My view of the interim report is that it would invite us, and perhaps the public who would read it, to come and say, "All these issues are important, but here are the issues that we feel are the most pressing." It will assist us to some degree in focusing our efforts. As a consequence of

that, it is my view that the interim report does not have to be too directive, too specific or contain recommendations. It is simply a report of where we are going from here.

Dr. Stoddart: That is pretty much how we see it. You might want to comment on this too, but our view of the interim report is that it will be a piece that has a large section just reporting the inventory of activities, the dollar expenditures, the amount of this and that and has some digestion of all the descriptive information. It may turn out to be 150 or 160 pages; who knows? Compared to that, there might be 10, 15 or 20 pages that say exactly what you just mentioned, namely, that on the basis of the work to date, the deliberations of the committee, the review of the literature and the descriptive inventory, the committee has identified the following high-priority areas for focus in the second phase of its activities.

There may be some violent reactions to the fact that certain things have been left off when that gets sent out, and we obviously have to react to them; but that has to happen at the preliminary report stage or it is going to be almost impossible to construct that grid, because there will be an infinity of items across the top. We would like to start that process later today by eliciting from you some questions that you absolutely know. Some specific questions are going to be on the columns of that grid. That is our view. The preliminary report is very consistent with what you just said.

Mr. Baetz: I want to comment on the process and just step back a bit. No doubt the two major sources of our data are going to be the two ministries most directly involved. As you have heard, we all got volumes of information--good information, I suppose--from the Ministry of Health particularly two days ago, but it is not very relevant to this question. The information from the Ministry of Community and Social Services is very voluminous and deals more directly with the question we are interested in here.

11:00

The presentation, particularly that of the Ministry of Health, however, is going to be a major point of concern. As we heard yesterday, in social services a very small percentage of the total expenditures is under the sponsorship of the commercial or for-profit sector. In view of the nature of the presentations, I am wondering whether an immediate next step for you would be to go through those presentations carefully--and they are rather large, as you have seen--and also to look at Hansard to see what discussion follows. By doing that, you can then identify a series of questions that you think either you will need to ask the two ministries or perhaps more appropriately in some cases should be asked by this committee, but do it in rather a systematic way.

I sense there is a real source of information there, but we do not have it. I suspect that perhaps the committee is not the right instrument to take an organized approach, to say what precisely they have said, whether in a quantitative way or even--there were some qualitative discussions as well. You identify the additional questions that you think this committee should be asking. Then within the next week or so, we should ask the two ministries to come back again or to provide answers to these questions to this committee or to our researchers. I throw this out as sort of a next step in the process.

Ms. Labelle: I think it is the logical next step. Obviously, we cannot proceed until we know what you perceived from the ministries. Unfortunately, we have not seen it so far, and it is very difficult for us to

discuss what may or may not be in those big black binders. Certainly, that would be the next step, and also to identify gaps in it.

I do not see the purpose of the committee to be specific on which data it would like collected. You can be specific on what you mean by commercialization. Do you want to look at all aspects of health and social services? We are going to get to those specific questions that we certainly do not have the expertise to address; they should be addressed by the committee.

I see the specifics of filling in the gaps, identifying future data sources and making sure that we have a comprehensive set of data from the two ministries as something that we probably can do with Cathy and the ministries of Health and Community and Social Services. There are some issues that you can address as well, and I hope we can get to them this afternoon.

Mr. Baetz: Sure.

Ms. Labelle: I do not want to jump the gun here, but you have suggested us going through those documents. That is definitely the next thing to do, to get in touch with the ministry folks.

Mr. Baetz: As a result of that review, ask a series of questions that you think might begin to fit into your plan.

Ms. Labelle: You do not want it to be our report, though.

Mr. Baetz: No. In this case you would be helping the committee organize its thinking and approach to the subject in a way that a committee normally would not do.

Dr. Stoddart: We had always envisioned, assuming we finished today, that we would spend as much of tomorrow as necessary with Cathy and perhaps Debbie to get some of these things in motion. The issue that we would seek some advice on from you is, would the committee be comfortable if we were to review that material with Cathy and write a letter? Is the committee comfortable having the chairman send a letter written by the research advisers to the Ministry of Health and the Ministry of Community and Social Services saying that we have reviewed the documentation, it is all very excellent, there are a few minor matters that we want to have some clarification on, and then sending a 10-page list? That is what may happen.

I think that is exactly what we should do, but is the committee comfortable having us proceed that way or does it want to see these letters brought before the committee and so on? We are happy to charge ahead if you are happy to have us do so and if we have the right to do so.

The Vice-Chairman: Do other members have points they want to bring forward with regard to phase 1 or do you want us to proceed to phase 2? Fair enough. Phase 2 then, please.

Ms. Labelle: We have touched on a few of the points in phase 2, so I will be fairly brief in outlining the agenda.

Phase 2 will be the analytic part of the research. We will take the information and the data gathered in phase 1, combined with reviews of other jurisdictions of the commercialization process, public hearings, testimonies, commission briefs, reports and presentations. All that material will be synthesized and the evaluation conducted.

The first step is to review the experience elsewhere. It will be a comprehensive literature review, which we know will be done by people other than ourselves, but it is an important first step. It will also help identify some issues we may not have thought of previously.

Once that has been completed, the data will be divided into categories for which we have a complete, comprehensive data set and categories for which there is only anecdotal evidence. I think an important finding of the committee will be deciding on whether evidence is usable, comprehensive, complete and sheds light on the question. It will resolve the anecdotal-versus-quantitative debate.

Within the category of quantitative data, two types of analysis will be conducted. The first will be conducted on services that are provided exclusively by either the public or private sector. Essentially, that will be a statement of the important dimensions such as costs and types of care, and it will get into some of the things that were mentioned earlier, such as breaches or violations of legislation and that sort of thing. We will go into the performance of the sectors, but we will not be able to compare across sectors, because the services are provided exclusively by one or the other.

The second type of research is a comparative analysis whereby we can identify services that are provided by both public and private sectors and can then compare across the sectors on important criteria. Obviously, that is the most comprehensive and most informative type of research. Unfortunately, not all services fall into that category, so we will be limited by the type of data and the existing structure of the service provision.

Again, an important step in this analytic phase is to identify the criteria across which we are going to assess performance. We have listed for you a few suggested criteria on pages 6 and 7, such as cost of care, quality, accessibility and some of the questions that can be addressed by information on those dimensions. This list is not meant to be comprehensive or exhaustive, and we are open to suggestions for additions or deletions.

That is basically what we intend to do.

Dr. Stoddart: You want to say one or two words about the background.

Ms. Labelle: A lot of the analysis will be done internally, but there are some portions of it that we feel would best be handled by contracting out to individuals who are experts in the field, who are familiar with what is going on and who can interpret what they think the situation is and assess the relative merits and weaknesses of the existing system.

Another option we considered is that in Ontario, especially in the area of health and, I suppose, to a lesser extent in social services, there are individuals who sit on either side of the debate and who have very strong feelings. Perhaps it would be useful to get background briefs presented by the two extreme positions, so that we have evidence on those two sides before we go into a public hearing. Again, this is all very preliminary and tentative, and we would hope to finalize this and harden it up after discussions with the committee.

Dr. Stoddart: One of the things we want to point out is that we do not envisage a huge, separate set of research studies coming out of this kind of budget and approach. When we talk about background papers, it may very well

be going to someone who has studied, for example, the costs of private sector provision of social services. What we are commissioning is a 15-page background paper. Do not go through the literature or the description; answer the following 10 questions in 15 pages.

11:10 a.m.

It is a very different kind of background paper to what select committees sometimes commission. We would hope to commission papers that are short, crisp, to the point and not very costly. Therefore, we have a much better chance of getting them on time from the contractors.

We think we may even be in the ball park of, say, 10 of those kinds of things. However, we do not see a select committee on health research studies one, two, three and so on--not at all. I think the committee has to feel comfortable with that general direction.

As Roberta said, the other thing we might like to do is program one or two people who have debated it in the academic and research literature to come before the committee, to stage exactly that debate about the evidence--instead of exchanging letters in the journals--and to let the committee question them about how this relates to the real world we have to deal with.

We would think about doing some different kinds of research activities to what select committees typically get, given that this committee has a very short time and does not, I believe, have the budget for the elaborate research activity you might wish. I think we are taking a very different view of research activity and of how to inform the committee.

We may come up with some things that are very different from what you are used to. I hope that is okay. If it is not, now is the time to speak up.

The Vice-Chairman: Do any of you have comments to make on phase 2?
Mr. Johnston?

Mr. R. F. Johnston: I think it makes eminent sense. Given our time lines, my only thought would be that this phase may be quite prolonged. We may not manage this phase in one set of hearings and research papers in a couple of months.

My own guess would be that after the first phase, as we start to hone down our questions and the areas of priority concern, we may end up with divisions, such as let us just deal with health in the first section of this and in health only these areas for now. If we start to draw the public to hearings on any one of those things, such as nursing homes, we cannot expect it to be something that will be dealt with in quick order. It just will not be.

I like the layout of this and the proposal. My guess would be that as we get into this, this will be the stage that becomes relatively prolonged before we get to phase 3 and the interpretation of research findings, both by yourself and by the committee, for policy reasons; or we may have to do it sector by sector.

Whatever comes out of that, this will be the extended period. The committee may start to decide a couple of things: that it does want to go into broader research in comparative terms and original research and to change our policy in some areas at that stage because of the deficit of information; or it may decide to divide up what we are doing in such a way that, given the

time constraints on a select committee and the committee's desire to be involved in the research in terms of questioning people and that kind of thing, this becomes the prolonged stage.

Ms. Labelle: As we discussed with the steering committee, we would feel much more comfortable with a longer time horizon, especially for the analysis phase. We were under the impression that we were severely constrained by the August deadline for the final report. If that can be negotiated or if it can be left tentative, that would be preferable. I do not know how strict the constraint is.

Mr. D. S. Cooke: I do not think we should curtail our activities or come out with a report that does not meet its objectives just because of the deadline. We can always go back to the House and ask for more time.

Dr. Stoddart: Phase 1 is not going to change much no matter what happens. If that is an option, then obviously we can adjust things a bit as we go in consultation with the committee. All we are saying is that we went away with a mandate to design a research plan that will get this done in a year with a budget of \$60,000 or \$70,000. We focused our thinking on achieving that.

Mr. D. S. Cooke: A number of things could affect the time, such as the few pieces of legislation that are coming down eight weeks out.

Interjection: Is there something we do not know about?

Mr. Polsinelli: Thirty-seven-day breaks.

Mr. R. F. Johnston: There is the health disciplines legislation.

Mr. D. S. Cooke: We always know two weeks ahead of time.

Mr. Wiseman: Are you writing more of the accord?

Mr. R. F. Johnston: Phase 2 of the accord.

Interjections.

Dr. Stoddart: The other issue is this issue of commissioning original research. We have adopted the position that the committee does not have the time or budget to do that, but should that change at the end of phase 1, obviously we can always--

Mr. R. F. Johnston: We might get an inclination of it after phase 1, but I think it will happen during phase 2 that we will start to realize either that there are large deficits in certain areas or that the public interest in one area is taking up a lot of our time and that kind of thing. I like the way this is laid out in theory at the moment in terms of how it might go.

Mr. Andrewes: I tend to agree. I would not want us to feel constrained by the August deadline, but on the other hand I am not sure that at this stage we want to say it is wonderfully flexible. We should move into phase 1 with the August deadline in mind to some degree. I have some concern about page 7, "Quality of Care." The first three categories tend to be somewhat subjective, probably more so two and three. "Is quality compromised when cost is minimized?" I wonder what statistical support you can get for those subjective viewpoints. What role do you see the hearings having in trying to identify measures of quality more specifically?

Ms. Labelle: I tried to make it sound more objective by saying, "Is quality compromised" rather than, "How much is quality compromised." The hearings will play a big role in raising issues around that question. What we can do as well, if we find services that are provided by both the public and private sectors, is to identify the relative costs in those two sectors and look at the outputs of the sectors in terms of type of care provided. There are other measures of quality that I do not want to get into now because there might be some discussion about them, things such as violations of acts. Although we might not be able to say, "Yes and it is compromised by a factor of three," we will be able to say generally either that costs are lower but there is no difference in quality, or that costs are lower and there is a lower quality, or that costs are lower and the quality is actually higher.

For services that are provided for both sectors, I hope we get answers that will not be based on anecdotal evidence and that will be backed up by statistics and data from the field. I suppose that is a utopian view of what we can generate, but if we narrow the focus of the investigations we can concentrate on getting those data for a few, perhaps one or two, select services. That is a big task in itself for the research studies you mentioned. I think it is important.

11:20

Dr. Stoddart: This is where co-ordination of what we are thinking about and the research side the committee is thinking about is important. I think the two words "focus" and "co-ordination" should be what we are striving for. One scenario that might happen is that the preliminary report might lay out a specific issue: for example, what is the relationship between quality, as measured by X, Y or Z violations, and cost? We might identify that there really is not much that we think is reliable or valid evidence in the literature on that specific question.

We might then--say, before the hearings--give a briefing to the committee stating, "Here are areas in which, if somebody makes a statement such as this, would the committee please challenge him to produce the statistics?" We may find in the course of public hearings that we cannot allow unsubstantiated claims to go unchallenged, and if people can produce the statistics, we would probably be more than happy to look at those statistics and ask: "Are they reliable? Are they valid? Can they be used to level those kinds of statistical analyses that we would have liked to have levelled in the first place but could not?"

There may be a really good opportunity in some scenarios, if we have the number of specific questions limited, to ask folks, "If you are saying that, what kind of evidence do you have to support that claim?" and turn it over to the research staff. There may be some iterations that can go on there.

Mr. Andrewes: I take it you feel the witnesses for the hearings should be selected to some degree.

Dr. Stoddart: We hope there will be a combination of whatever the committee decides about contributions and advertising. We see that as entirely something the committee will decide on.

We would like to suggest to the committee, after the phase 1 work, some individuals, experts or vested interests whom we would very much like to have before the committee and we would like to be able to offer the committee some questions we think they should be asked on the basis of what we are currently missing or what we found in the research. Does that seem reasonable?

Mr. Andrewes: Fair enough.

Dr. Stoddart: We see the public hearings as a golden opportunity, if people have claims they can substantiate on unpublished data, to have them investigated and brought forward. If they have claims they cannot substantiate, they deserve to be exposed.

Mr. D. S. Cooke: As long as they are not members of the committee.

Dr. Stoddart: I cannot imagine that happening.

Mr. Wiseman: I am just sitting in this week on the committee, but I wonder whether any other province has entertained an in-depth study to get a handle on costs to see whether it was getting good value for money. Have we checked with the other provinces? If we have, and if they have done it, we may find areas in which you can assist the committee by saying, "Other provinces have done an in-depth study in this way, and there have been areas that they all seem to find need some work done where they are not getting good value for their money." Or we could compare the final report, whenever it comes in, to see whether the same thing is happening right across the board. Maybe it has been done in one of the states and we could check our findings against that.

Where you mentioned earlier that you probably cannot get a handle on the cost of a bed being whatever it is and whether you are getting good value for your money, perhaps on a province-wide basis or comparing it--I guess south of the border they are quite a bit more expensive--but province by province you could probably get a handle on whether we are out of the ball park or whether we are in it, or where they have found difficulties, if they have already gone through an exercise such as we are doing here.

Dr. Stoddart: The short answer would be that if such reports exist, they will be captured, in researcher's language, by letters we will write, which I hope the committee will sign and send to other provinces to get the unpublished data.

Mr. Wiseman: At present you do not know of any.

Dr. Stoddart: The longer answer is that I have discussed, with a contact in the Department of National Health and Welfare and with people who work on the federal-provincial advisory committees, the current activities in several provinces. The short summary would be that British Columbia is not, to our knowledge, doing anything of this nature, because it essentially has its hands full with the court challenge on manpower; that nothing of this nature, a study of commercialization, is going on in Alberta; to our knowledge, nothing of this nature is going on in Saskatchewan.

These days, Manitoba is focusing the efforts of its research and planning branch on alternative delivery and modalities, and that is a huge development. There has just been a whole series of papers put out in Manitoba suggesting a redirection of the organization and financing of the health endeavours in the province. These papers would be of more appropriate interest to the Evans task force than to the specific focus of this committee.

Quebec currently has the Rochon commission under way, which is essentially a 20-year review of the Castonguay Nepveu report, redirecting the health system in that province back in the late 1960s or whatever. I have spoken with Jean Rochon and will be finding out whether there is anything from that committee's report that is relevant to this committee.

My understanding is that, whether or not there is a report, Newfoundland has actually made some decisions about solving the overall corporate planning problem in the health sector. It intends to go in the privatization direction more than it has in the past, especially with respect to hospital services. I have to confirm that, but that is the general picture there.

I do not know anything about Prince Edward Island, but we would obviously get in touch. To my knowledge, there is nothing going on in that direction in Nova Scotia. There is some activity in the New Brunswick Ministry of Health about overall response to the general cost pressure in the health sector. We have some contacts there and will be in touch with them.

I think the basic message coming out of a cross-Canada review, from people we talk to regularly, is that commercialization is being seen as only one policy option or one issue in a broad spectrum of policy issues, all motivated by the same basic crunch, which is that it is very difficult to evaluate whether you are getting value for money in the health care sector. In addition, the health sector in all the provinces of Canada is organized in such a way that there is financing without any management. There are very few incentives in the health sector, and all provinces are trying to find some way of rationalizing utilization patterns without regulating them. Existing program commitments leave very little room for innovation, such as alternative delivery modalities, so that all the provinces and commissioners I have talked to in the last little while are saying the problems are basically much bigger than private-public mix. There are really major planning problems for Ontario in this case, with a \$9-billion corporation.

I can assure you we will be in touch with the various provinces and we will include what we learn in the literature review.

Mr. Andrewes: You just echoed in about two sentences what Dr. Mustard said today.

Dr. Stoddart: He told you in two sentences?

Mr. Andrewes: You did.

Dr. Stoddart: That is unusual. Friends will tell you that is unusual when he and I talk.

Mr. Reycraft: With the discussion we have had about the research that is going to go on in phase 2, I would like to go back to a matter Mr. Johnston raised concerning phase 1--and I see him leaving, so--

Mr. R. F. Johnston: It was a good time to raise it.

Mr. Reycraft: No matter how we go about preparing the interim report, no matter how much analysis of ministry information is done and no matter how much research is done, in the interim report there are going to be errors made and inaccuracies included. There are going to be omissions and areas that get missed completely.

I guess Mr. Johnston was suggesting there should be some research done subsequent to the ministry presentation and an analysis of the information we have received from both ministries. I wonder whether that is not premature. Should not that kind of research come after there has been an opportunity for affected groups, interest groups and expert witnesses to look at the interim report and identify those things?

11:30

Ms. Labelle: I do not think the data-gathering exercises would necessarily be cut off with the interim report. They would likely be an ongoing part of the research. If we want to get information from sources other than ministries, the lead time necessary to get the data we want is quite long. Inevitably, it takes a few tries. If we wait until after the interim report or until after the hearings, it could be that we do not get the data we need until next summer. For a comprehensive picture of what is going on, I think we should approach as many people as possible right now.

The other thing is that although the ministries tend to be fairly good at keeping track of what they do, in the past they have not been as good at keeping track of what the private sector does. The private sector has much more detailed information, for example, on the cost structure of its services, which the ministry would not be able to give us. I think if we approach them now, we will have a more complete data bank from which to decide what information would be included in the interim report and what would be used for subsequent analyses.

Mr. Reycraft: Are you satisfied that you are not going to end up in almost the same situation after you do an analysis of the ministry information and after the interim report comes out, and have to fill in the holes?

Ms. Labelle: I think the whole process will be a continuous filling in of holes. It would be nice if we could get as much as possible at the beginning so that the holes are few and far between. I would be reluctant to rely exclusively on ministry data for the interim report. I think that opens up the committee to a challenge that it has not been comprehensive in gathering information, that it has ignored some other relevant information that is fairly easy to access but does not happen to be in the domain of the ministries and that it has been tainted by what the ministries see as the view of the world.

Whether or not we include all the information in the interim report, I do not see any serious problems with embarking on getting it right now. I see that it could be a serious problem if we do not. I do not know whether I am answering your question.

Mr. D. S. Cooke: Do you see in this process the likelihood of this committee to be dealing with some of the questions of physicians' services and alternatives? Are you looking at the physicians' offices as being private sector?

Dr. Stoddart: Those are some of the questions we want to get into in clarifying what the committee means by commercialization. I do not know what the general schedule of the committee is. It usually sits until 12:30, does it not?

Mr. Johnston: We have been sitting until 12.

Dr. Stoddart: Then it goes from two o'clock to four o'clock. Could I put that on hold and mark it as an issue?

Mr. D. S. Cooke: Yes.

Dr. Stoddart: Because we have as our first item of clarification with the committee, our interpretation and your interpretation of

commercialization. We will run a few things by the committee and say: "What about this?" I wonder whether it would make any sense to try to push through the broad-brush review of the outline with questions along the way and then get to the stage of opening this afternoon by clarifying things and making decisions about "This means that; it does not mean that," so the research can go on.

The Vice-Chairman: Mr. Wiseman, do you have a question now, before we start this?

Mr. Wiseman: Perhaps my question is not relevant to this. With nursing homes being under the two ministries, will we be researching the possible savings of amalgamating them under one ministry and perhaps eliminating duplication of staff in both ministries? It is confusing as heck to the general public that some of them are under extended care in the homes for the aged and yet the rest all come under the umbrella of the Ministry of Health. Maybe I am wrong, but I always felt there was a great saving there to the people if they were all under the one umbrella, plus being a little easier for the general public to understand.

Ms. Labelle: I wish I could answer that for you. I hope we will be able to answer it for you a year from now.

That has been a claim, and that type of question is something we would like to address by talking to people in the ministries and by looking at reports that have come out recommending that they be amalgamated.

Again, it would be fine for me to give you my opinion. That is not really valid. We would want an overview of what the pros and cons are and to make sure we have captured all the arguments for and against. I hope we will address that, but I cannot answer it for you now.

Dr. Stoddart: That is a good example of the process we would like to go through with the committee. We will be suggesting to you at the end of the day that if you have specific questions, send them along, because we need to create the pool of questions from which we think the high priority ones will come.

Mr. Wiseman: There is another one in there that has never been eliminated. I had hoped it would have been back in 1975 or so. For a person over 75, one still has to put in a long-stay report, pay a doctor to do it and bug the devil out of the doctor to get it.

Many of those people probably never improve enough to get out of an extended care bed; maybe they end up in a chronic care one as they get older. Yet every month or 60 days, the doctor is paid a fee for filling out that report.

That would save a lot plus, I knew at that time, some manpower. Whether it was the lack of losing that manpower or some director being shifted or losing his job, it never was done. That is a real saving and a humane thing, because the chances of their improving after they reach 75, to the point they can get out of extended care, are pretty limited.

Ms. Labelle: Again, that is a fairly specific question and we may or may not address it. Although I thought the main purpose of the study was to evaluate the performance, extent and scope of commercial for-profit activities, I would see doing that by comparing what is going in the private sector to that in the public sector.

I do not think we understand a main thrust of the committee's work is to identify all the inefficiencies that may or may not exist in the public sector and restructure the Ministry of Health or the Ministry of Community and Social Services. Inasmuch as they have an effect on the delivery of care and if one sector has a better handle on how to cope with that--

Mr. Wiseman: It has to do with costs and whether you are getting value for your money.

Ms. Labelle: Yes.

Dr. Stoddart: A variety of issues could come up, and we encourage committee members to write down any specific questions they want to see data levelled on. This is a little premature to know whether the data will be able to be levelled on that.

At some point in the fall, I hope we are going to get the committee together for a day on the issue of narrowing or prioritizing some of the questions. At that point, those kinds of questions can be reintroduced by us or by you and discussed with committee colleagues. At this stage, all specific questions are helpful, even though we know we cannot level research on all of them.

The Vice-Chairman: Are there any more points to be made before we proceed to phase 3? If not, let us proceed.

Dr. Stoddart: Phase 3 could be fairly fast.

Ms. Labelle: That is your section.

Dr. Stoddart: Unlike the last six pages of detailed research outline which Ms. Labelle prepared, phase 3 was written by me.

The Vice-Chairman: I admire how you set up the work schedule.

11:40

Dr. Stoddart: In fairness, it is very difficult to tell you what the research staff involvement and activities will be in phase 3. The key point is to say that phase 3 will be characterized by an opening presentation which tries to summarize and synthesize the research, the grid and so on. We will then be in the hands of the committee with regard to how it wants to use the research staff to interpret findings and how much involvement it wants of the research staff in proceeding to draft recommendations.

As we will come to in the budget, we do not envision at this stage that the research staff is going to write the final report, nor does that seem appropriate, although you may want Cathy to draft certain sections, based on the grid of information and the synthesis.

Therefore, phase 3 will be decided once the committee sees what it has before it and once it has decided how it wants to use its research staff at that time. I do not think there is really much to say about phase 3 at this stage, other than the fact that I am sure everyone looks forward to the day when he will have all this information and can fight about recommendations.

The Vice-Chairman: Any comments or questions?

Mr. Baetz: It is fairly appropriate, as someone who has engaged in social research for many years, that your job is one of data collection, compilation and analysis. The policy recommendations coming out of that, however, go over to the policymakers. Right?

Dr. Stoddart: That is certainly how we see it. We would be happy to interpret findings or give opinions on the impact of certain recommendations, but we do not see our role as that of drafting recommendations.

Mr. Baetz: I see.

Dr. Stoddart: Would you want us to do it?

Mr. Baetz: No. We cannot duck out of that one. That is our role.

Dr. Stoddart: We are allowed to influence students' minds, but not those of the general public.

The Vice-Chairman: Are there any other points you would like to fill out before noon?

Dr. Stoddart: As a general principle, if we could push through the outline and then come back to some detailed discussion on meatier research points in the afternoon, that would be great.

The Vice-Chairman: Of course.

Mr. Andrewes: Did you write this?

Dr. Stoddart: Actually, we worked fairly closely on it. The writing tasks got divided a little differently. Is that right?

Ms. Labelle: Would you like me to read the critical path?

Dr. Stoddart: Yes.

Ms. Labelle: I think it is fairly straightforward. I do not need to read out the various points.

There are three crucial dates we would like to confirm: the submission of the interim report, the holding of the public hearings and the submission of the final report. We talked a bit about the submission of the final report, and I understand that it is more flexible than we previously thought, but we will still proceed as if August is the deadline, unless something that would indicate otherwise comes up.

Would it be December for the interim report? We talked about that. How about January and February for the hearings?

Mr. D. S. Cooke: That will be very difficult for us. That is what we should shoot for--not too early in January, though. Some of us like to go down south in January.

Mr. Andrewes: Are we committed to the calendar now?

Mr. D. S. Cooke: In the rules? No.

Mr. Polsinelli: I thought we were committed to the new rules.

Mr. D. S. Cooke: We are committed to the new rules, but there is no calendar for the Legislature in the new rules. That was one of the recommendations that was not accepted.

Mr. Polsinelli: Too bad.

Mr. D. S. Cooke: Two out of three of us were in favour of it.

Dr. Stoddart: The general outlook on the critical path is that this is a really tight path for an August deadline. We hope we can co-ordinate, focus and so on, but just as a general comment, this is a very tight research time path for the number of things we are trying to get done.

One variable that we will have some control over, although not total control, is elusiveness, as Roberta so nicely put it here: "devise strategies for pursuing unco-operative or elusive data sources." We really do not have much of a feel for that and we hope the committee can lend its weight, as necessary, to encourage some of these data sources to co-operate.

Mr. Baetz: In making my comments earlier about the quality or nature of the reports given by the two ministries a few days ago, I was not suggesting that there was any kind of deliberate withholding of information, but we did not get in many cases the kind of information that was useful to us.

Mr. D. S. Cooke: That was probably because we were not all that helpful to them ahead of time in telling them exactly what we wanted.

Mr. Baetz: It could well be, and this is why I urged earlier that one of the early things the researchers should do is help the committee and the ministries identify more precisely exactly what information we want.

Mr. D. S. Cooke: So everything is approved now and we just pass that motion?

Miss Stephenson: It is not going to work, David.

Dr. Stoddart: Actually, when I talked about elusive and unco-operative data sources I had more in mind some of the private sector enterprises that we have had to deal with in the past than the ministries. It may not be always totally in their interest to co-operate. I think we have to be honest with them.

The Vice-Chairman: Are there any more points anybody would like to make at this time? If not, would you like to proceed?

Dr. Stoddart: Section 4 of the research plan is what we will come back to this afternoon; we will start this afternoon there. The last thing I want to do this morning is give you a sense of what this preliminary budget looks like and, more important, a sense of the assumptions on which it is based, because they have some considerable implications for roles of people and for understanding how we will work with the committee.

That budget figure is in the ball park that we talked about at the steering committee. Let me make a few comments to start with. Some of the variables in here are unknown. How much the committee wants to make use of the research advisers over and above things that we will have to do anyway is certainly unknown.

The cost of contracting out some of the private data collection to a firm such as Research Innovations is also unknown. If the committee wants it, we can break down for the committee the split of the days during the various phases that Roberta and I had anticipated we would each spend. We do have a plan for how many days per phase, but that seems to me to be something that might be changed as we go.

The overheads to McMaster University reflect the factors that I discussed with the steering committee last time.

The one point I think is important here is that we have no sense of what the other expenses of the committee will be. This is a budget for the research activities. I do not know, for example, whether there are other expenses associated with the printing of the final reports. Perhaps we can all talk about that tomorrow as part of the administrative arrangements. I want to emphasize that this is for the activities described as research plans.

I also want to point out that there is no separate research study publication budgeted for here. As far as the research side goes, we have budgeted small amounts for travel, which reflect our ability to come in and out of Toronto and for Cathy to come down perhaps to collect data here and there and so on. We have not envisioned any major travel associated with this research plan.

Mr. D. S. Cooke: We will take care of that.

Dr. Stoddart: We ourselves are not planning on going anywhere. Hamilton is such a beautiful environment that I cannot imagine leaving it for the coming year.

The Vice-Chairman: Can we figure that Hamilton to Toronto at rush hour in the morning is a major trip?

Dr. Stoddart: That is a fact. Again, just quickly running through some of the assumptions, there will be 10 background papers at \$1,000 each or some equivalent. That is the order of magnitude we are talking about there. We are assuming there is some flexibility between line items in a budget such as this. It is not a detailed budget.

In terms of our roles as the architects of this research endeavour and the advisers, we are assuming the committee wants us to monitor the performance of some of the people who are doing the research and to work closely with Cathy.

11:50

We are assuming that Cathy will probably be taking a large responsibility for drafting the descriptive parts of the interim report and working with the data that come in from various sources. We will work with her to set a structure for that, but we are assuming that the committee is not going to be asking us to do all that writing.

We are again assuming that since we are working with Cathy, she can essentially keep the grid during phase 2 of the information obtained by various sources or activities, classified by the policy issue it relates to.

We are assuming the committee will want only limited attendance by us at public hearings--in other words, at key hearings around issues that the research plan would love to get some evidence from. We anticipate the committee would like us to brief it on the status of the research and on what might be useful questions to ask of persons appearing before it, but otherwise, the committee is probably not going to want us to be there every day. This sort of budget implies a 10 per cent to 15 per cent attendance rate by us. If that changes, it is something we can discuss.

Similarly, it assumes limited attendance by us at the phase 3 discussions, once we have presented to the committee the accumulated information from the research phase. Again, that can be discussed. If the committee really wants us there on a daily basis to interpret findings, that would have to be something different.

It assumes the committee would, in conjunction with Cathy, probably draft the final report, and it assumes, as we noted earlier with the steering committee, that no original research studies going right back to first principles are being commissioned. Those are the assumptions on which the budget is based.

Mr. Andrewes: On the question of witnesses before the committee, other than those who would come voluntarily as a result of advertisements or whatever, would you recommend that we ask certain people to appear? If so, would we be responsible as a committee for their travel and would there be a per diem involved in their time in preparing for their appearance?

Dr. Stoddart: That is a decision the committee itself will have to make, once we show it what evidence we have from the research and what gaps are still unfilled. We would be happy to suggest to the committee whether we think that gap might be filled by inviting a certain person or asking a certain person or organization representative to appear.

It is a good question whether the committee is then responsible for the cost of that. This might be in the category of other costs that Debbie, Cathy, Roberta and I should chat about with respect to whether those are additional costs of the hearings or things we cannot know about. I do not know. What is the normal procedure when a committee asks someone to appear? Does the committee reimburse that person?

Mr. Andrewes: Normally.

Clerk of the Committee: May I answer that? The normal practice is that if a committee asks a person to appear before it and if that person asks to be reimbursed, the committee will reimburse him. We do not in general go out and say, "If you come, we will pay for your expenses," but if that person asks to be reimbursed, there is a policy that if the committee specifically invites him, then he will be. There is an allowance in the budget for that.

Mr. Andrewes: What I was leading up to was item 3, background papers and commentaries, whether that was in there to cover that particular situation.

Dr. Stoddart: No. What we have in mind there is what I was talking about earlier where, instead of major research studies, we will suggest to the committee that it say to someone: "Write us a 10-page paper. Do not give us a lot of the normal academic stuff. Get down to the point and answer this question, and you will get \$1,000 for doing it, appearing before the

committee, preparing the presentation and answering questions." That is the sort of thing I had in mind, much crisper background papers, but those would be the ones we would think about. Whether we make it 20 pages and \$2,000 is neither here nor there. We are thinking about people we would like to see commissioned to do things and not people we are requesting to appear before the committee because they are in an organization we think should come and speak to some of the evidence.

The Vice-Chairman: Are there any other comments or questions? If not, we will recess until two o'clock this afternoon. Excellent.

The committee recessed at 11:55 a.m.

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SELECT COMMITTEE ON HEALTH

COMMERCIALIZATION OF HUMAN SERVICES

THURSDAY, AUGUST 28, 1986

Afternoon Sitting

SELECT COMMITTEE ON HEALTH

CHAIRMAN: Callahan, R. V. (Brampton L)
Andrewes, P. W. (Lincoln PC)
Baetz, R. C. (Ottawa West PC)
Cooke, D. S. (Windsor-Riverside NDP)
Johnston, R. F. (Scarborough West NDP)
Poirier, J. (Prescott-Russell L)
Polisinelli, C. (Yorkview L)
Reycraft, D. R. (Middlesex L)
Sargent, E. C. (Grey-Bruce L)
Stephenson, B. M. (York Mills PC)
Turner, J. M. (Peterborough PC)

Substitution:

Wiseman, D. J. (Lanark PC) for Mr. Turner

Clerk: Deller, D.

Staff:

Fooks, C., Research Officer, Legislative Research Service

Witnesses:

Stoddart, Dr. G. L., Associate Professor, Department of Clinical
Epidemiology and Biostatistics, and Associate Member, Department of
Economics, McMaster University
Labelle, R., Lecturer, Department of Clinical Epidemiology and
Biostatistics, McMaster University

LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON HEALTH

Thursday, August 28, 1986

The committee resumed at 2:10 p.m. in committee room 2.

COMMERCIALIZATION OF HUMAN SERVICES
(continued)

Mr. Chairman: I understand the committee got to the budget this morning. Did we complete that discussion?

Dr. Stoddart: As far as we are concerned, it was completed. If the committee has any further questions, that is fine.

Mr. Chairman: Does the committee have further questions on the budget? I asked the clerk if the budget included a group we talked about using, Research Innovations. Is there something in that budget?

Dr. Stoddart: There is an amount in the budget for collection of certain pieces of information on a contracted-out basis. If the committee has already promised some arrangement to Research Innovations, we will be happy to honour it. We would like to meet with them and ascertain how interested they are in doing it, the way the research plan calls for, their capability to do it and whether they will do it for the price in the budget. Those are the variables about which, until we meet with them--which is planned as one of the first steps--it would be tough to give a definite answer.

Mr. Chairman: I gather the committee is content with the approach that we will meet with these people to see if they are prepared to do it.

Mr. R. F. Johnston: I do not believe that was discussed much.

Mr. Andrewes: No.

Mr. Sargent: In view of the unknowns ahead of us, time frame, etc., why are we hanging on a budget of \$68,000? Why not make it \$100,000?

Mr. Chairman: Let us get the \$68,000 through first.

Mr. Sargent: Seriously, if you have travel planned, you need enough to cover it.

Mr. Chairman: I would like to go back to Richard and then I hope I can answer that question.

Mr. R. F. Johnston: There are a couple of things I would go back to in the budget. My sense is that decisions about which other research assistants we should get, decisions made by the steering committee and the architects, as they describe themselves, would be the best way to move to ascertain whether the particular group or other individual researchers, or a mix of those, would be the appropriate ones to prepare the inventory we are talking about.

Personally, as a member who is not on the steering committee, I would be

happy to leave that kind of decision-making to the steering committee members and to Dr. Stoddard and Ms. Labelle to work out.

Mr. Chairman: The only reason I suggested we give some direction at this point is that it may well be it would result in a change of the budget, which would mean coming back to the committee to get ratification. We all had an opportunity, you will recall, to hear various people. We were impressed by the way in which they might help us. Dr. Stoddard and Ms. Labelle have indicated they would be prepared to talk to them to see if there could be a mutual meeting of the minds in terms of the data they can collect and whether they are prepared to do it on a contractual basis. That would seem the most expeditious way to get on with it. It would save coming back to the committee.

Mr. R. F. Johnston: I do not know. My own sense is that if you want control over it, then you should have a member of the committee involved. At least you are not losing control; I personally do not think you want that. I presume you will rely very heavily on the advice you get, but to have the decision made by the research group we are contracting to and without our having some say in it would be an error. That is my view.

Mr. Chairman: With respect, I do not think we are doing that, because we did interview--and I am not sure whether you were in attendance--

Mr. R. F. Johnston: I was not involved in the interviews, but I was involved in the discussion afterwards. We as a committee made no decisions about using that group at that time and, as far as I am concerned, we still have not done so. I would prefer to have that decision made by some representative members of this committee and by Stoddard and Labelle, but not by Stoddard and Labelle alone. I do not think that is appropriate.

Mr. Keycraft: Particularly because of the lack of a definitive nature as far as research is concerned, it may very well be that, as Mr. Sargent has suggested, we may need to go back for supplementary funding for the committee. If that occurs, proposals such as Mr. Johnston has made, where the steering committee is involved in approval of this funding, would put us in a much better position to obtain approval of additional funding.

Mr. Chairman: You talk about a supplementary budget. I do not know whether Mr. Sargent is aware of it, but we do not even have the first one through the Board of Internal Economy. If we are going to do it, I suppose we should do so at this point as best we can.

Mr. Keycraft: We are doing that, but still we cannot be certain. There is some vagueness to the amount of research that is going to be required. That is quite natural, given the nature of the project.

Mr. Chairman: Unless anyone else is in the same frame of mind as I am with this--

Dr. Stoddard: We would appreciate close consultation on several issues of research design and the operation of the committee during the next few months, with at least the steering committee. One of the issues we want to raise later is how we will work with the committee to complete the phase 1 activities, because ideally there will be a couple of meetings with the committee as a whole to work through this list of issues and to put some priorities into that. That is a separate subject.

We would be very unhappy if we did not think we could consult frequently

with the steering committee to make sure that the research design matches the committee's evolving thoughts on the matter.

Mr. Chairman: It sounds as though I have lost. I am a good loser.

Perhaps we can move to the next item. I understand we were going to go back to the research issues for some clarification and questions by members of the committee.

Interjection.

Mr. Andrewes: We went through the budget.

Dr. Stoddart: We left part 4 to return to this afternoon, because this is, in a sense, where the meat of what needs to be decided immediately lies. These are issues that, at a steering committee meeting, we suggested we would bring back to the committee and would try to present to you what the question is in each case and what some of the implications are of deciding it one way or the other. These questions need to be discussed in order for anything to be done on the research side in phase 1, and specifically for us to engage in meeting with anyone who might do the inventory.

One way of going about it is to take one at a time. Either Roberta or I will discuss what we think are some of the implications and we will get the committee's thoughts. We hope the committee will be able to agree on the interpretation of these things.

Point (a) may not be a huge question, but it is not clear to us, either from the terms of reference or from the discussion in the steering committee, whether for publicly financed or provided services the committee sees itself as dealing only with services provided by the Ministry of Health and by the Ministry of Community and Social Services or whether the committee sees its work as entailing the coverage of human services provided in, say, the health area by the Ministry of Labour or other ministries.

Fraser Mustard probably talked to you about the broad description of health and health care. If Fraser spoke yesterday as he used to speak at McMaster, I am sure almost anything could be included in . . .

Mr. Chairman: He was excellent.

Dr. Stoddart: He is good--in the broad area of health, including environmental programs and services from many other ministries. What is the feeling of the committee?

14:20

Mr. Chairman: I have a list; Richard Johnston first.

Mr. R. F. Johnston: There is a danger of our going into a too broad definition of health and including environmental issues and that kind of thing, for some of the very same reasons you say we cannot do primary research on some of the comparative things. The scope of the committee then gets to be pretty diffuse.

However, there are some specific programs in other ministries that perhaps we should be gearing into because they relate very directly to services we will be looking at. An example I raised yesterday was the

corrections question. The correctional facilities for juveniles--the 16-year-olds and younger--are handled under the Ministry of Community and Social Services, but the 16-year-olds to 18-year-olds in this province are handled under the Ministry of Correctional Services, unlike any other jurisdiction in the country that I can think of at the moment. There is a feeling among some critics that the two ministries handle the question of privatization quite differently. Therefore, getting some of that information would be useful to us.

I am not sure whether there are problems under the Ministry of Labour. Perhaps Dr. Stephenson would be able to think of some that might apply directly that we might be able to look at.

Miss Stephenson: Occupational health might be one of the areas. I have a little greater difficulty relating occupational safety quite so directly to the study as safety rather than health. However, the occupational health area could be included.

Mr. D. S. Cooke: How would that relate to the privatization issue?

Miss Stephenson: The use of private laboratories with specific capability for analysis of ambient air and all sorts of other things. The public health laboratory in Ontario, although one of the most advanced in the country, does not have all the capabilities, nor, I am afraid, do all the university labs have all the capability to do some of the testing that really needs to be done. That is one of the areas that probably needs to be addressed at some point.

Mr. Baetz: I was going to say essentially the same thing Mr. Johnston pointed out. We identified yesterday an example of where we may have to look into another ministry. In this case, it was the Ministry of Correctional Services. We would be well advised to start this research, as with any research, with as narrow a focus as possible. Where it becomes obvious that it needs to spill out a little bit, we should do so, but let us not start off by trying to examine the universe. It is all very exciting, as we heard from Dr. Mustard yesterday. There are some wonderful questions out there, but this committee should start specifically, primarily with these two ministries. Where it looks logical and we need to examine segments of others, we should go ahead and do it.

Mr. Andrewes: I wrote "yes" behind item 4(a). That is my vote.

Mr. Chairman: Are there any further comments by the committee? Mr. Johnston, are you content with the approach Mr. Baetz is professing?

Mr. R. F. Johnston: Yes. I think Mr. Baetz and I are on the same wavelength on this.

Mr. Chairman: Does that give you sufficient direction in that regard?

Dr. Stoddart: I think so. As matters or other areas are brought to the committee's attention from whatever direction, please pass them on, check them out and make sure they are on our list. We hope Cathy can be a liaison if we are not around at that particular moment.

Mr. Chairman: She says yes. We have her on the record for that fact.

Dr. Stoddart: She is on the record for a lot more this morning.

Mr. Chairman: I believe it. Perhaps you would like to move on to (b)?

Ms. Labelle: We were wondering whether the committee's interpretation of the word "commercialization" had purely private sector, for-profit connotations. What about private not-for-profit? Is that included? How do you want the analysis to be broken down? Do you want a public versus private for-profit comparison or analysis?

Mr. Chairman: Who wants to tackle that one?

Dr. Stoddart: Let me add one thing here. Our interpretation of the steering committee discussion, the terms of reference and the general debate, as we have investigated it in the past for other purposes, is that most people mean by "commercialization" private for-profit provision of services. That may or may not be an acceptable working definition. As Roberta said, you can see at least two other sectors, the private not-for-profit and public.

The other issue that Roberta raised with me--I do not know whether she wants to raise it with the committee--is the issue of provision versus financing.

Ms. Labelle: There is a whole set of dimensions to what privatization means. You can have privatization of ownership of facilities, of management functions or of the financing side. Are we interested in that? Again, our grid is becoming three-dimensional. A narrow definition, and the typical definition, is the ownership aspect. If there is private, for-profit ownership of a facility or of labour, in the case of, say, physicians, then that will fall under the narrow definition. In Ontario, we are now seeing activities that do not necessarily involve ownership--for example, hospital management--also being privatized or commercialized. We are wondering whether you are interested in examining those functions as well as the private for-profit ownership.

Mr. Chairman: Perhaps even a public facility where the property is owned by private individuals in an equity position.

Ms. Labelle: It is happening with hospitals.

Mr. R. F. Johnston: My sense is that the definition of commercialization is correct, but I sense what we want to look at is the range of options, which includes the private not-for-profit as well, the government is looking at. In terms of the definition of commercialization, I would not disagree with that. In terms of the second matter, I think it has to be the full range of items including management, not just straight ownership, because of the reasons you are suggesting around hospitals and other kinds of services--paramedics, home support services and others--coming in. That has to be a broader definition, but I agree with the specific distinction between privatization and commercialization that you have in your definition.

Ms. Labelle: Can I raise a further question? Are you interested specifically in the private provision of care or are you interested as well in things such as private insurance, private dental insurance or supplementary insurance for noninsured benefits?

Miss Stephenson: There are private not-for-profit insurance programs already run by some of the unions that are considered to be very important adjuncts at present to the delivery of services. They need to be looked at as well.

Mr. D. S. Cooke: When we are looking at private insurance, we are not really talking of denticare, for example, something that government has decided to privatize. The government never decided to make it public policy that there would be a public denticare program.

Ms. Labelle: I thought they just made that public statement.

Mr. D. S. Cooke: No. I realize that. You know what I mean. There is not a denticare program, so how would we narrow it? Why look at Richardson Greenshields or London Life or any of those agencies? What would we learn?

Miss Stephenson: You are going to look at Blue Cross as a private not-for-profit agency providing for supplemental services.

Mr. R. F. Johnston: Richardson Greenshields is nonprofit?

Miss Stephenson: Not-for-profit, the drug plan.

Ms. Labelle: Which does not mean they do not make a profit.

Mr. Chairman: I never understood that to be the case.

May I interject? This committee certainly wishes to delve into these matters, but when we get too far from the terms of reference, we start to expand out and pretty soon we will be examining the things that are really way out there. I think personally, from the insurance aspect, we are getting too far afield.

14:30

Miss Stephenson: One of the concerns researchers must have is the way in which the committee feels it should explore the financial underpinnings of whatever it is a jurisdiction should provide in support of its citizens. I do not think you can look at all this without having some concern about the way in which it is financed, can you?

Dr. Stoddart: No, it is certainly a part of it. Right now, in the phase I aspect, it is certainly a part of the description of what is being done.

We can get into this a bit, but I think some serious policy questions on financing that you want dealt with will be coming up, for which it would be nice to have some information.

The danger of that is that if there are already 20 policy questions motivating this committee which have historical roots, whether they be nursing homes or whatever, and we come up with 20 more for you and you want research on all those, this is not a one-year endeavour. What we talked about this morning is prioritizing this long list of issues some time around November or December to see which ones are the most important.

Right now, the significance of phase I is that if we take a very broad definition, we will have to see what somebody such as Research Innovations says when we tell it all the things we want it to collect data on, if we cannot get it from published documents that Cathy already has or if we cannot get it easily. There is that aspect to it.

Miss Stephenson: You triggered something. I hope the report on nursing homes, which was carried out by a task force that was appointed a year and a half ago, will be available to us. It is said to be sitting on the minister's desk at the moment.

Mr. D. S. Cooke: Are you talking about the review of the inspection branch?

Miss Stephenson: No, not just that.

Mr. Chairman: Before we get into that, Dr. Stephenson, Mr. Baetz has been waiting patiently.

Mr. Baetz: Yes. I would like to ask Richard Johnston a question. When he says we should include a private not-for-profit, would he, by that definition, then include voluntary agencies?

Mr. Chairman: Are you back at paragraph (a)?

Mr. R. F. Johnston: No. At the start.

Mr. Chairman: Oh, I am sorry.

Mr. Baetz: I am just asking for clarification because if you mean all voluntary agencies, we are then really into a pretty big bag. For example, the Red Cross is a private not-for-profit which operates a few outpost hospitals and a homemakers' service. You can go right down the line where a lot of them are providing services under voluntary agency auspices, some very similar to those carried out by provincial or municipal agencies.

I am not arguing against it, but if we do get into that, we should be aware that we are then into a pretty big study.

Mr. R. F. Johnston: I am arguing that, yes, we should, but what I want to argue is that we are talking here especially about phase 1. As Dr. Stoddart was saying on that point, I also think that means the insurance and that type of thing should be data we try to pull together in phase 1. It may very well be that as we move to phase 2, we will decide there are full sections that we will now leave alone.

I do not know the Ministry of Health as well, but looking at the Ministry of Community and Social Services you definitely have direct government provision in the home support service area, purchased from nonprofits and profits. Therefore, it does make sense to look at what the Red Cross is doing there versus Para-Med, as an example.

I think we do need to pull that information in phase 1. As we select our priorities, we may choose other things to go after in public hearings and in the further research side of things, but I think we have to do it in the initial collection.

Mr. Baetz: For example, if we follow that road, then one could very well look at the whole question of the national blood transfusion service in the Red Cross Society. It is under voluntary auspices. From time to time, it has been argued--not by many--that it should be under more public auspices. Are we prepared to get into that study?

Miss Stephenson: May I just make a plea, having gone through the battle that led to the centralization of transfusion services in the Red Cross some 30 years ago--

Mr. Baetz: I was there.

Miss Stephenson: --that we not get into any kind of battle to do it the other way?

Mr. D. S. Cooke: Are we not going to be looking at each and every service or program provided by the ministries? Are we not basically going to look at some and decide on the basic principles or the criteria involved before there is a decision on whether it is provided in the private sector, the not-for-profit sector or the government sector?

Miss Stephenson: Or all three.

Mr. R. F. Johnston: For instance, in Community and Social Services, most services for the elderly are provided by nonprofits in the community and by the voluntary sector. For our initial development of information you would list, that is the case. The government has already given us that kind of thing, and we could map that out. How they work is quite straightforward, and the range of program is primarily limited to those. We should put that down--because that then juxtaposes with the provision of homemaker services, which is done in a mixed bag--and why, in comparison with that. That does raise further legitimate policy questions.

Mr. Chairman: You are jumping ahead to item (c), as I see it. Are you suggesting that in the interim report, we get this whole bag put before us and then pick out of that bag what we want to go on to in phase 2?

Mr. R. F. Johnston: That has been the suggestion in the presentation.

Mr. Sargent: I do not know whether my question is relevant, but are we inventing the wheel or is there any place an existing parallel to this?

Mr. Chairman: Inflating the tire is what we are doing.

Mr. Sargent: Yes, but is it intelligent to ask how you get a doctor to work for the money involved here unless he is getting a piece of the action? Are the medical doctors not a pretty strong component of this?

Miss Stephenson: Yes, but they are not the only component; they are a strong component.

Mr. R. F. Johnston: Can we get doctors who will work with us is the question?

Miss Stephenson: For \$80,000 a year, yes.

Mr. R. F. Johnston: It is \$93,000 plus his pension.

Miss Stephenson: Holy cats.

Mr. Chairman: I feel as though I have lost control of this meeting.

Miss Stephenson: Yes, you have.

Mr. Chairman: It was much better this morning.

Mr. R. F. Johnston: I have just sprung to the defence of the doctors for the first time in my life.

Mr. Chairman: Poirier is a tougher guy than I am. He probably kept you all in line. Where did we get to?

Miss Stephenson: Eddie's question is a very good one and one we have to think about seriously. Are we reinventing the wheel? You said, "No, we are inflating the tire." Yesterday I thought we might be going to design a new vehicle.

Ms. Labelle: I am lost right now. I think we are on the auto line.

Miss Stephenson: Join the club.

Ms. Labelle: As long as I am thinking the same as everyone else.

That is more properly dealt with under part (d), where we ask about the services we are interested in examining. Physician services are one of the top priorities there.

Can I go back to make sure I understand the answer the committee has given to B, that commercialization is meant to mean private for-profit, but the scope of examination will include, as well as private for-profit, private not-for-profit and public.

Dr. Stoddart: Can I just clarify something on that score too? What I heard about process was that you would like to cast the net as widely as possible in phase 1, see what you catch and ferret out the things that are of interest. After people have had a longer time to think about them and after you have seen what they are, when the research staff says, "This is what it means," you will have a chance to react. Is that fair enough?

You do not want to exclude anything at the outset. If you do know there are things you want to exclude at the outset, it would be extremely helpful to pass those things on to us.

Mr. Chairman: I had attributed that motive to Richard's comment; that what we are doing is casting. I do not know whether that was an accurate statement of what you guys were saying.

14:40

Mr. D. S. Cooke: I think we should try to restrict it to things that are already provided by the ministries. If we start getting into private insurance, I do not know, but maybe if we take a look at the select committee on company law, there may already be some comments about the private insurance companies about 12 years ago. The private insurance companies alone would take an incredible amount of time. Do we really need to do that?

Miss Stephenson: No one is suggesting that you do an immediate study of private insurance companies. It is simply where there is a supplemental program which is being provided. Obviously, that demonstrates there is perhaps some need for a supplemental program. I do not know.

Mr. D. S. Cooke: We are not.

Miss Stephenson: Is that phase 2?

Mr. D. S. Cooke: The mandate of this committee is not to decide new services that should be provided. The mandate of this committee is to determine what criteria are used to determine whether it is in the private for-profit sector, the private sector, or the government sector. We are not going to recommend that denticare be instituted in this province.

Miss Stephenson: I was not suggesting that at all. I was suggesting that I thought the concept that we determine what is in place now in terms of both the delivery of care and the financial support for whatever is delivered should be reported to us so that we have the complete picture, and then decide the areas upon which we want to concentrate in determining the directions the committee should pursue.

Mr. Chairman: I think we have just confused the issue again.

Miss Stephenson: I thought that is what I heard you say.

Dr. Stoddart: We are in agreement with both ideas. The only thing I would like to add is that I think it would be important, certainly from the point of view of the research activities, that between now and the end of phase 1, the committee make it clear that phase 1 is just to paint a picture of the current situation. Even though in phase 1 there may be some data collected on private insurance, the committee has by no means decided--in fact, it has not--that one of the policy issues it wants to address seriously in phase 2 is private insurance.

My sense from previous work is that it will not be very long before you have the public hearings filled up with private insurance firms. Unless you believe that is a serious policy issue which should bump off the quality of care in nursing homes from public hearings, I think you want to be very clear with folks that the fact that we are collecting data by no means implies this will be a serious policy question.

Miss Stephenson: I guess that is one of the reasons why I am concerned about the use of the word "commercialization." It seems to mislead people in all sorts of directions. I would be happier if we just got rid of the word.

Ms. Labelle: I am concerned about how much we are putting on the agenda for the interim report, since Cathy and I will likely be having to search out all this data.

The interpretation of the terms of reference suggested by Miss Stephenson is fairly broad. The specific terms of reference state that the committee should examine the commercialization of health and social service sectors. They refer to health care and social services. Insurance is not health care and it is not a social service. It is a health-related service. I was wondering at the outset if we could restrict initially the inventory at least to health care and social services and not health-related services such as insurance, just as we have restricted our examination initially to the Ministry of Community and Social Services and the Ministry of Health.

After we have the preliminary inventory, we might review what we have. If it looks as if we should expand and use a broader interpretation of the terms of reference, then we could perhaps proceed to do it. At least initially we should see what we have. We might be fishing in a pond that is already full of fish and we do not need to load the nets any more right now.

Dr. Stoddart: Is this the base principle applied to this new era?

Ms. Labelle: Yes. The base principle applied to part (c).

Mr. Chairman: Is there a consensus that we proceed in that way?

Mr. D. S. Cooke: There seems to be.

Mr. Chairman: I wonder whether there is now. Is there a consensus to proceed the way Ms. Labelle has suggested?

Miss Stephenson: A consensus can be a simple majority. That is perfectly--

Mr. Chairman: I was not going to call a vote on it or anything.

Miss Stephenson: I believe an integral part of all this activity is the way in which it is funded. All I am asking for is simply a delineation on a sheet of paper, which should not be too difficult, of those areas that are not currently supported by public funding but that are supplemented through various kinds of insurance programs, in order to ensure that services are provided. Some of those services are provided under public programs in some areas and are not utilized by those who have the insurance program; therefore, I think it is integrated. But if the committee wants to ignore that, that is fine.

Mr. R. F. Johnston: Generally speaking, I am in agreement with what Dr. Stephenson is saying and I wonder whether we are not creating more problems for ourselves in--

Mr. D. S. Cooke: Same old game.

Mr. R. F. Johnston: Yes, the same old game--by necessarily saying, "Let us separate out and look at the insurance funding of things." When we look at all these matters, we will look at how rates are developed for various programs and where the money comes from that. We will be looking at services and care. Therefore, when we talk about dental care, which I presume we will look at, we will say: "This is what is covered by the Ontario health insurance plan; these things are not. Certain people purchase this way, these kinds of services and that sort of thing. That is what exists."

Miss Stephenson: Certain physiotherapy services, other kinds of things, which are in fact benefits.

Mr. D. S. Cooke: I wonder whether we will spell out in the interim report which ones we are going to spend time on in phase 2 so that no one will be misled into thinking he can make presentations on insurance or whatever.

Miss Stephenson: Exactly.

Dr. Stoddart: That is what I am mostly concerned about: the signals that get sent out between now and the end of November.

Mr. R. F. Johnston: I am sure there is a large difference in the collection of the material, with which I agree, in terms of the amount of time we are going to be putting into it. You do not want to overburden that. But there is a difference between collecting that material and writing a report, which includes some of that, does not include other parts of it and states our priorities fairly clearly.

Mr. Chairman: Ms. Labelle's concern, as I read it, is that she and Cathy are going to be involved in the initial staging of this interim report. If the net is cast too wide, then that interim report may be delayed until February.

Ms. Labelle: Yes. I do not know whether perhaps I can restate this a different way. We will cover a lot of the issues raised by Dr. Stephenson when we look at the specific services, when we look at dental care. Who pays for the dental care?

Miss Stephenson: That is fine as long as it is in there. That is all I am concerned about.

Ms. Labelle: What I would suggest that we avoid, at least at the outset, is looking at how private dental insurance plans are funded, how much is employer paid--

Miss Stephenson: No, that was not my intent at all.

Ms. Labelle: Great.

Miss Stephenson: My intent was simply to list, primarily for the benefit of members of the committee from time to time--because there are some areas that I do not know about, I can tell you--that there are programs of health care in this province or health-related social care that may be publicly funded under some circumstances and that under other circumstances are funded through private insurance. Those two means have to be included in our first phase so that we are aware there are two routes to the same goal.

Ms. Labelle: Yes. In fact, in our research outline we suggested that collecting data-- Where is it? We have it on page 5, point 7: collecting data on charges or payments incurred by the users of the services, both rates and fees and as a proportion of the total cost of the service, including information on criteria for exemption. Would you be satisfied with that?

Miss Stephenson: Yes.

Ms. Labelle: Okay. Great.

Miss Stephenson: I simply want to make sure that among all these data there is an understanding of all the areas that are currently covered through private insurance plans and of those areas in which that is not a duplication but a supplement to what is being provided. However, as long it is there, that is all that matters.

Dr. Stoddart: Certainly it is there.

Miss Stephenson: I do not care how you do it, but I really am not suggesting that you look at the whole mechanism of establishing health care insurance--not at this point. You will do it at some other time, I know, but not right now.

Ms. Labelle: That is fine.

Dr. Stoddart: In the consultation process we will talk about for the fall, there will be a chance to refine things if people are unhappy with too much depth or too little depth.

Miss Stephenson: Fine.

14:50

Mr. Sargent: Will you make a summation of where we stand now?

Mr. Chairman: I beg your pardon?

Mr. Sargent: Will you make a brief summation? Where do we stand now?

Mr. Chairman: If you will look at page 11, we have dealt with items (a) and (b) thus far, and I suppose we have talked around (c).

Mr. D. S. Cooke: For the first time in my life, I have come to the conclusion that Dr. Stephenson is right.

Miss Stephenson: That has to be a first. I hope you do not collapse with--

Mr. Chairman: Do you want that on or off the record?

Mr. R. F. Johnston: The mike was on. I think we have done 4(a) and 4(b) at this stage.

Mr. Chairman: I am sorry, Mr. Sargent. Were you referring to an analysis or a capsulized form of where we are?

Miss Stephenson: This is the page we are working on now. We have agreed to 4(a) and 4(b); actually, we have almost completed 4(c).

Mr. Chairman: We have almost done 4(c).

Interjection: The first round.

Dr. Stoddart: Yes. My understanding on 4(c) is that the answer is it should cover all three categories. I think Roberta's and my understanding of (a) and (b) is that we are, above all, to proceed sensibly, taking into account that the committee wants to start widely and get descriptive information and that the committee knows it will narrow down or else the second phase of the research will be difficult. Is that, in so many words, a fair sense of (a), (b) and (c)?

Mr. Chairman: Do you want a motion on that?

Clerk of the Committee: No.

Mr. Chairman: Can we go to (d)?

Clerk of the Committee: I have written down some of the things on which I think there was consensus. If you like, I can go through them. Would that be helpful?

Miss Stephenson: She is going to answer Mr. Sargent.

Mr. Chairman: Just do not reopen it; that is all.

Clerk of the Committee: For 4(a), it was decided on research looking into the services provided by the Ministry of Health and the Ministry of Community and Social Services. In certain instances where ministries with similar services were provided in a different manner--there is your example of the Ministry of Correctional Services, where Community and Social Services handles it up to the age of 16 and Correctional Services after, and they handle that issue quite differently--those may end up coming into the overall examination, and as Mr. Baetz suggested, research would begin on that narrow frame and then broaden where necessary.

For (b), the definition of commercialization is private for-profit, but private not-for-profit and public services should also be examined; somebody said the net should be cast widely.

Miss Stephenson: We test it and then we cast it widely.

Clerk of the Committee: In the first phase of the examination, when you are gathering the data; but then as we move on to phase 2, it can be narrowed down where the committee decides there are areas that may not need to be examined as closely, the initial inventory to be restricted to health care and social services and not broadened out to health-related services.

For (c), it should cover all three areas. Is that what everybody agreed to?

Mr. R. F. Johnston: The only thing on the last one is that it very well may be that, even though it may include all those things, in deciding what goes into the final report we may exclude certain kinds of information. However, in the preparation for the report, that is what we are looking at. The committee might make different decisions about that by the time it gets all that information.

Mr. Chairman: Is that (d) you are referring to?

Mr. R. F. Johnston: It is (c) in the design of that report.

Interjection.

Mr. R. F. Johnston: From then into December we might very well decide that we want only 50 pages and not the huge accumulation we have. We might limit it more. Let us say that is our goal.

Mr. Chairman: Can we move on to (d)?

Ms. Labelle: There are three questions we are asking you in (d). First of all, we are asking you to identify those services or types of care that you think are high priority and on which we should spend the extra effort in getting more information you want to see examined. Second, are there any specific policy questions relating to those areas? Again, this will help us in determining the nature and extent of the data. Third, what will the criteria be for assessing performance for the provision of services? That information would help us in collecting the right types of data.

Dr. Stoddart: Previously we have been asking you what you want to exclude. What we are saying here is, these things do not have to be done until

until the end of phase 1, but if this committee knows already that it is going to end up on two, three or four things that cannot possibly be excluded and are certainly going to be included and become the focus--

Mr. D. S. Cooke: Do you already know?

Dr. Stoddart: I am just asking. If you know that, and if you have any sense of agreement or consensus on that, let us get that out so we can be doing a little better job on those things in phase 1, and be a little more ready for phase 2.

Mr. Chairman: Okay. Mr. Sargent is first.

Mr. Sargent: I want to apologize for missing this morning. I hope this does not slow up what you are saying, but it would seem to me if we could use as a building block the health maintenance organization experience in the Sault and the steelworkers' union as a living example of what we would like to build around, then you could add all the frills you want on top of that. That is a basic situation we are shooting at, I would imagine; I do not know. It is a proven success track record up there, and that might be something worth while to think about.

Mr. Chairman: It sounds almost like a wish list. You have had Eddie's wish list. Richard, did you have your hand up?

Mr. R. F. Johnston: No, but I will pretend I did.

Mr. Chairman: Nobody else did.

Miss Stephenson: I had mine up.

Mr. Chairman: I am sorry.

Miss Stephenson: After Richard.

Mr. R. F. Johnston: Looking at the policy questions, it is clear to me that the question of HSOs as community health centres versus fee-for-service doctor approaches and other kinds of things--

Miss Stephenson: Care is what you are talking about.

Mr. R. F. Johnston: --will obviously be things we will want to look at. Nursing homes obviously will be something we want to look at, and day care. The easier way to do it, rather than doing it now, would be to do the review of what we were given by the two ministries. A bunch of them jump out immediately from that.

As you have already mentioned, it is going to be quite important for the steering committee to meet with you fairly frequently at the beginning of this as exclusions become apparent, so we weed those early and get them out of the way early.

Those are things off the top of my head that I would look at. Corrections, young offender stuff in terms of the institutional, for-profit and nonprofit mixes, is one thing in which I am very interested in terms of options.

Miss Stephenson: This may be a little far down the road, but there are some ethical issues in which I believe public bodies are going to have to

play a part, at least in discussion, in terms of delivery of health care. I am thinking of two or three areas that are becoming exceedingly expensive, and although the value is unquestioned in terms of the preservation or delivery of life, society really has to consider seriously whether it is going to pursue them or not.

The first one that comes to mind is the whole series of definitively, genetically related diseases, which now can be identified in terms of the frequency with which they will occur in parents who have the same kind of genetic characteristics.

I think of phenylketonuria, for example, where the costs right now in terms of diet for that child, usually for the first 10 to 15 years of life, are something of the order of \$12,000 a year specifically, in addition to everything else.

We know that when girls who have had PKU have been controlled, mature and become pregnant, they have a greater than 50 per cent chance of producing PKU children and you have the same problem compounding itself. Therefore, is there an ethical consideration which society should be bringing into this whole area of the advance of technology in terms of life?

For example, is it rational to say that any young woman who has grown out of PKU, as they say in the vernacular, should be sterilized and not be permitted to have children because we know the frequency with which that very severe and expensive problem will arise again? There are other problems much like that.

15:00

Mr. R. F. Johnston: I do not disagree that there are number of major ethical questions coming up or upon us now, but how are we going to relate those to privatization and commercialization?

Miss Stephenson: One of the things that worries me is that if one of the problems we have is expecting that the tax burden is not going to be capable of providing all the advantages that science can provide for humanity, we have to look to other means of injecting funds, and privatization is one of those.

The injection of private management companies is a way of ensuring that the tax burden will be reduced. That is just one significant part of the whole aspect of commercialization of delivery of program. All I am saying is that there is a whole range of other things. I am probably a long way down the road from where we are ever going to get, but these are some of the things that should be in the minds of the members of the committee.

I would also suggest that perhaps we should be seriously considering the kinds of rules that are dominant in the minds of practising physicians: They must do absolutely everything they can to preserve life, no matter how disastrous the situation seems to be. Are there circumstances in which adults should have the opportunity to say: "Do not do that. It is my life; let me decide what to do with it"?

Mr. R. F. Johnston: Not to get into the debate on this, I do not disagree that we will have to look at those questions, because they and others are rising in the medical field at the moment.

Miss Stephenson: They should be rising right now in your field, in the social services.

Mr. R. F. Johnston: Things such as experimentation and other things rise there as well.

Miss Stephenson: Yes.

Mr. R. F. Johnston: My sense is that we will need to keep those in our minds as we do things, as you say.

Miss Stephenson: That is all I am asking you to do.

Mr. R. F. Johnston: However, our emphasis should be on where that interacts with the question of commercialization and privatization. For our purposes, only where there is that direct impact should we spend much time on it.

Mr. D. S. Cooke: One point on private capital: You raise the problem of increasing costs and some of the things that will contribute to them. The whole idea of private capital and whether that is one of the solutions is something this committee has to look at.

Miss Stephenson: Yes.

Mr. D. S. Cooke: It has to be one of the priorities.

Mr. Chairman: Mr. Stoddart wanted to ask a question.

Dr. Stoddart: I wanted to pick up on Dr. Stephenson's comment, because unfortunately she was not able to be here this morning when we talked about something which might relate to that.

This may be the time now around the question of health service organizations, health maintenance organizations and future bioethical commercial issues. This morning we talked about the levels at which the committee might view its activities and suggested there was the very narrow one, which could be simply an examination of the private for-profit sector alone.

At level 2, which is in the middle of page 3 of our proposal, we said the committee would basically come down to saying it wants to look at the private for-profit juxtaposed or compared with private for-profit and public. Level 3 brings in the whole issue of the private-public mix versus other major corporate planning issues in this sector for the government and any ministry. There are some very fundamental issues there.

In the phase 3 deliberations of the committee in structuring a final report, I suggest the committee might want to consider putting in a section about where it believes the public-private mix to be on a list of priority issues to be resolved, versus bioethics, manpower planning and other things.

It seems to me there is a whole series of issues the committee could put into a process for public discussion in this province without trying to resolve them.

Miss Stephenson: You are right; it probably is a phase 3 issue, but it is or should be of concern to all of us. It is a matter that should be

thought about by everyone who has any responsibility in the expenditure of public funds, whether public funds should be expended in large amounts for purposes of very specific individual satisfaction.

I do not have any problem with in vitro fertilization and the scientific miracle that has produced that, and I certainly rejoice with the parents. I just wonder whether the lunch-pail-carrying taxpayer should be responsible for expending funds in support of an extremely expensive procedure for that purpose or whether we should be suggesting to social workers that they do not tell all the 13-year-olds to keep their babies but put them out for adoption, so that some of those parents who want to might have families to look after without going through all of that.

There is a whole range of these things, and I do not think you can consider any aspect of advancement of delivery of care in either the social field or the medical field at present without thinking about them, without having them in the back of your mind all the time.

Dr. Stoddart: May I reply to that one? I have two reactions to that. One is that with respect to the process of the committee and the research process, should the committee at some point decide it does not want to discuss those issues, the role the research process might play--and this is not in any of the current budget activity--it may be worth while to provide a synthesis on some of the key issues or key services of what is known about the costs, the effects--

Miss Stephenson: And the burdens.

Dr. Stoddart: --and the burden of the benefits. That would be the role we would feel comfortable with. Of course, that goes on all the time at places such as McMaster or other health science centres where costs and effects are estimated. It is obviously the appropriate role for the committee to think about: who should pay or should not pay.

The second thing is something I think the committee might want to spend a moment on now. We understand the terms of reference to be not just talking about the role the commercial sector plays now and maybe what it should play with respect to services currently provided, but the committee may feel it wants to consider what role the commercial sector should play in the long-term future, the kind Dr. Stephenson is talking about.

In that context there may be one or two very large issues that could conceivably dominate some of the public hearings, should the committee want to get into them, and these relate directly to commercialization. How is the market for organs to be organized? Is it to be allowed to be a private monetary exchange? Is it to be set up as the open market? I do not use "the market" in a pejorative sense, but in its true sense as an exchange mechanism. Is it to be set up as the market for blood products?

Those are issues of direct relevance on the commercialization subject, yet some people might see them as being well off in the future. They are advancing very quickly. I do not know. The question for the committee is to think about that, because we will come back to you. We want to know what you want to do about that. That is the tip of an iceberg.

Mr. Andrewes: I hope no one will take exception to these comments. At the outset, I am a pragmatist. I have never developed the patience of an academic, and I have never developed the skills of a professional such as a

lawyer or a doctor. I have to be able to see the light at the end of the tunnel. It seems to me that the object of this exercise is to find some measure of quality versus cost and how the two interrelate. If we do that, I think we will have made a hell of a success of this committee. We are throwing into the mix a number of things that will lengthen the tunnel and diminish the light.

15:10

Mr. Sargent: Another train coming.

Mr. Andrewes: I am getting a little concerned.

Mr. Chairman: Eddie's a pragmatist too.

Dr. Stoddart: You may have heard that some folks who studied the Canadian health care system in its initial tremendous success and now the sort of constraints and problems it is running into have concluded the system is a good example of the tunnel at the end of the light.

Mr. Chairman: It has to be understood that apparently there is going to be a committee under Dr. Evans which may run concurrently with ours at some point and deal with a lot of these issues, and if we are going to run the same thing I agree with Mr. Andrewes that we have a problem.

A more important one is a sensitivity problem. You start putting that into the interim report and I can guarantee you that you will have every person here from the pro-life to the pro-choice because that is at the root of many of the arguments about the question of whether you pull the plug on the ageing people or whether the people have become too old and you decide it is time to send them on to their just reward because you cannot afford to look after them.

I appreciate what Dr. Stephenson is saying in terms of the very exotic types of operation, such as in vitro fertilization or heart transplants, but I can tell you right now that those groups out there will react to that, and if you think you will have insurance industries in here if you go into the insurance thing, you will have groups in here lined up all the way down the hall. You will have to barricade the doors, I will venture to say. That will interfere with what we are supposed to do.

Miss Stephenson: Mr. Chairman, may I respond to that? It was not my intention that there would be any specific mention of these subjects in the interim report, perhaps not even in the second report which this committee produces. All I am saying is that the members of this committee, if they are really going to do their job, have some very important questions to keep in mind constantly while they are doing what they set out to do, that everything is not clear black and white, neatly defined and set in little boxes.

There are a lot of interwoven problems which have to be examined and unfortunately society does not like to examine them. Society would rather leave them to somebody else to look at or simply ignore them completely and you are not going to be able to do that. We are going to be overburdened on this planet and we are going to have to make some decisions, unfortunately.

Mr. Chairman: Richard, you had your hand up.

Mr. R. F. Johnston: Did I? I think we should move on. I understood Dr. Stephenson to be saying that.

Miss Stephenson: Thank you.

Mr. R. F. Johnston: I tried to clarify that 20 minutes ago or whenever it was, but with my usual capacity I managed to blur it even more.

Miss Stephenson: Obviously we were both blurring it.

Mr. R. F. Johnston: Did Dr. Stoddart or Ms. Labelle have anything in mind around major performance criteria?

Ms. Labelle: Since you raised it, I thought if we concentrated on gathering information on cost, quality and accessibility, that would probably allow us to address most of the major policy questions that I think have or will be raised. If the committee is in agreement with that, that is where we would proceed.

Mr. R. F. Johnston: I have a point that you may have already considered to be within that combination of cost, quality and accessibility and that would be accountability.

Miss Stephenson: Is not accountability a part of cost?

Mr. R. F. Johnston: That is what I am asking. I want to be clear.

Miss Stephenson: I suppose it is. It would have to be defined.

Ms. Labelle: We can fit all sorts of things, but we would generally put that into a quality area for examination. That was part of the criteria set that I was considering.

Mr. Chairman: Any further questions or suggestions from committee members or from Dr. Stoddart or Ms. Labelle? Have we dealt with 2(d)?

Ms. Labelle: For now.

Dr. Stoddart: I think so.

Mr. R. F. Johnston: Is it possible for the committee to maintain a fairly close liaison with the researchers during the next few months?

Mr. D. S. Cooke: Anything is possible.

Mr. Chairman: Do you want us to move in with them?

Mr. R. F. Johnston: I have always felt that to be a matter of private choice.

Mr. Chairman: Will they contact us and arrange when they wish to speak to us?

Dr. Stoddart: If the committee does not have anything else it wants to move on to, we had one last category. We have covered a lot of things, but the administrative arrangements that we need to set up can done in a meeting with Cathy and Debbie tomorrow. They can transmit to you, Mr. Chairman, any other concerns or requests, but I do not think there will be any.

Roberta and I wanted to use a few moments before we call it a day to talk about first steps and to tell you what we think the first steps are and

to let you suggest other things that you think might be necessary to mobilize the research effort.

Tomorrow morning we will meet with Debbie and Cathy to review what has gone on to date in meetings we have not been here for, to look at some of the information from the ministries and to set up a process whereby, especially with Cathy, we can communicate and start to construct the structure of phase 1 activities.

Next on the list, as suggested, we should draft letters to the Ministry of Health and the Ministry of Community and Social Services, having reviewed their material, and specify some of the additional pieces of information or different breakdowns that would be necessary, given what this research plan calls for.

Another first step is to arrange a meeting with Research Innovations to find out its capabilities, now that we have a better sense of what the committee means by "commercialization" and how widely it wants to cast the net and so on. We hope to have a meeting with them and Cathy.

Those are some initial things. Roberta, do you have anything you want to add to that?

Ms. Labelle: No.

Dr. Stoddart: After those activities have occurred in the next couple of weeks, we would like to get back together with the steering committee. If we can arrange that through our contacts with Debbie and Cathy, that would be fine from our point of view. If the committee would like something more formal on a regular basis, that is also fine. If we could get together with the steering committee on an ad hoc basis and through it perhaps arrange later in the fall for the committee to sit again for a day or two at the end of phase 1 when we need to do some of this focusing and prioritizing for phase 2, in an overview sense, that would be how we would like to proceed. I do not know whether that is acceptable, reasonable or feasible to the committee.

Mr. D. S. Cooke: The steering committee can meet but I would hope the steering committee will not make any major decisions on narrowing or directing. I am on the steering committee but what we decide now, initially, is obviously going to set the stage for what is going to happen in January or February in the final report. I do not think you, as chairman, should feel uncomfortable with trying to call the full committee together if we are going to be making decisions.

Mr. Chairman: By the way, we are meeting at Winston's restaurant on those steering committee meetings. I thought I would tell everyone right now.

Mr. R. F. Johnston: Are they open to all members? That is how we operate in the standing committee on social development.

Mr. Baetz: On this letter that you are proposing to send to the two ministries after you have reviewed--

Dr. Stoddart: I am proposing the chairman send it.

Mr. Baetz: I was going to make that suggestion. I think it might be better.

Mr. Chairman: But they will be drafting it.

Mr. Baetz: Obviously, you are going to be drafting it, writing it or proposing the content of it.

Mr. Chairman: So when someone shows it to me someday and says, "Did you write this?" I can say, "No, but I signed it."

Mr. R. F. Johnston: I have two things. First, I agree with Mr. Cooke about major meetings. We should try to meet as a committee on those decisions during the fall.

Second, I want to come back to the question of the hiring of other researchers to do work. It seems to me that is a decision in which it is very important for the committee to be involved. I am willing to have that done through the steering committee. However, Dr. Stoddart, I was not clear from your suggestion about the meeting with Research Innovations whether it would then make decisions or whether you are waiting a couple of weeks before you meet with the steering committee to recommend to it specific research projects that Innovations would take on, etc.

15:20

Miss Stephenson: Or others.

Dr. Stoddart: Or others, right. Perhaps I was not very clear. Let me be as clear as I can about this. We see ourselves as research advisers to the committee. We have constructed a plan. We would like to undertake on the committee's behalf to make recommendations to the committee about who it might contract out certain pieces of research to and what those pieces of research should look like. We would be happy to write the performance specifications for those contracts. We would be happy to monitor them should the committee choose to make the decision to contract them. We would see very clearly that all actual research not done by us ourselves would be an employer-employee relationship between the committee--not us--and the actual researchers.

We talked about this to the steering committee and the steering committee initially asked us whether we wanted to be a general contractor. That is where we came back and said no; rather, we would be architects. We see ourselves as research advisers. Under no circumstances will we make any financial decisions or major policy decisions, as it were, about the research without clearing it with the steering committee and, in fact, asking the steering committee to take the responsibility for deciding on behalf of the committee or calling the committee together. Is that clear?

Mr. Chairman: That is clear enough.

Mr. R. F. Johnston: That is what I would like.

Mr. Baetz: I am not on the steering committee. Can someone tell me in about one minute why you did not want to play the general contractor role for the research that is going to be going on? It seems to me it would have been a much tighter operation if you had.

Dr. Stoddart: I can tell you pretty clearly. We would have had to withdraw because we could not take that kind of time away from our university commitment to our graduate students and to our colleagues in the health economics and policy analysis course at McMaster. It would not be fair or ethical.

Mr. Baetz: There is a mechanism built in, I gather. You are the mechanism to make sure that we get the quality of research which you expect and we want, are you?

Mr. Chairman: They said they will monitor that.

Miss Stephenson: The architects' role obviously ensures that they will be assessing the capability of the trades persons and contractors.

Mr. Chairman: Telling us when to make the next draw.

Dr. Stoddart: Also, as we specified this morning, although we do not see ourselves doing a lot of the nitty-gritty writing, we had previously talked to Cathy and it is fair to say that she is not only willing but also quite interested in taking on a fairly challenging role in that part of it. We will be working closely with Cathy to set up in advance the kinds of structures that we talked about this morning, so that as information comes in, it will not just sit there and six months later somebody has to say, "What do we make of all this?" We will have some kind of a grid in which to synthesize these various pieces of information and we will be successful, we hope, in getting you to focus so that we can be focused by May. We anticipate working closely with Cathy and working very closely in consultation with the steering committee and monitoring things the steering committee contracts for on our recommendation.

In the research environment it would be a much different job if we had to go out every day on the pavement and get these data ourselves. We could not do that, given our roles in the university.

Mr. R. F. Johnston: I gather this was considered the final matter we would be discussing, but, having had to run out to my rehab before lunch, I am not clear whether, when the budget was discussed, a vote was taken on the budget or where we are on that.

Miss Stephenson: I gather it was suggested that we are going to talk about the budget tomorrow morning. The question I have is why can we not do it now?

Mr. Chairman: I do not think so.

Dr. Stoddart: That was not my understanding.

Miss Stephenson: That is good. That is what I heard this morning.

Mr. Chairman: I gathered from what has now been said that we may not have to meet tomorrow morning. I can go to my dental appointment, if it has not already been cancelled.

Dr. Stoddart: As we said at the outset today, we would love to complete the work with the committee as a whole today. We want to get going on the nitty-gritty with Cathy tomorrow.

Miss Stephenson: Good. I wondered how you were going to do all that work with Cathy tomorrow if you were going to meet with us.

Mr. R. F. Johnston: Mr. Cooke has a suggestion on the budget.

Mr. D. S. Cooke: My only suggestion is that instead of \$68,900 you should add a contingency and put it at \$75,000.

Mr. Chairman: Are there any thoughts on that?

Mr. D. S. Cooke: I do not want to have to go--I do not have to go, but I do not think you want to go back again to the Board of Internal Economy. I would have a little bit of extra.

Mr. Chairman: I have some comments or some requests of committee members after we have dealt with this issue. How does \$75,000 sound?

Mr. Sargent: How about \$100,000?

Mr. R. F. Johnston: What is a million dollars?

Mr. D. S. Cooke: The other \$25,000 you are talking about--

Mr. Sargent: It is a multimillion-dollar package we are looking at, and you are wandering around worrying about \$30,000.

Mr. Chairman: Do you want to go and argue it at the Board of Internal Economy, Eddy? I like that approach.

Mr. Sargent: Yes, I will do that.

Mr. R. F. Johnston: Fiscal responsibility.

Mr. D. S. Cooke: We have to save that other \$25,000 for our trip to Sweden.

Mr. R. F. Johnston: Yes, that is true.

Mr. Sargent: They could send us down to Australia.

Mr. D. S. Cooke: That is even better, because we are going in the winter.

Interjections.

Miss Stephenson: This is phase 1.

Mr. Chairman: Yes. As Dr. Stephenson has indicated, as I understand it, this is phase 1 anyway.

Dr. Stoddart: No, it is not. My understanding is that that is not correct, that this is a budget--

Maybe I should just review--

Miss Stephenson: That would help.

Dr. Stoddart: It is pretty important that this not be misunderstood. I am happy to go through the assumptions that created the budget again if people would like me to do so.

Mr. Chairman: All right.

Mr. Polsinelli: Do you regret that we are not putting in a \$100,000 budget?

Dr. Stoddart: No, I do not regret that at all. It may turn out that we have to go to that, but that will be your decision, based on the information you get, not ours.

This budget was drawn up on the assumption, obtained from the steering committee, that the select committee on health was to report within a year, not to cost an arm and a leg, to be in the \$60,000-to-\$70,000 range and to do what we could with that budget. That is why we decided not to go for separately published research studies, not to go for travel nor to go for crisp background documents, or even small debates among experts staged for the committee. That is why we chose a different research strategy.

In coming up with these figures, for example, the inventory of commercial sector activity, which we may or may not be able to get done for \$25,000, is in the first phase. The literature search will be commissioned in the first phase as soon as we can get it structured, but we expect it to be handed in around February or March for completion on the critical path, assuming an August deadline, to be synthesized for presentation in May.

The background papers and commentaries will occur during the second phase. We have a breakdown of our time, which we have worked out ourselves, about how those days will be spread across all three phases. As I said before, the assumption there is that you would prefer limited attendance at hearings and limited attendance during your phase 3 policy discussion meetings, and that you would like us to monitor the research but not to get involved heavily in the writing of the report. There are some assumptions with respect to our time there. Basically, it relates to all three phases.

With the qualifications I gave this morning about some of the unknowns and the qualification that this does not allow for new, original research to be commissioned but rather research on existing data or evaluative research, comparative research, our intent was that this would produce the documents we described in this research outline for this committee with that budget, all three phases. You may decide yourselves that there really are other things you want, compared to what is in this outline.

Miss Stephenson: But we are likely to know that more definitively once we have completed phase 1.

Dr. Stoddart: I think so.

Miss Stephenson: Then we may have to modify this budget.

Mr. R. F. Johnston: The reason I think a contingency is not a bad idea is that the largest single expenditure is the phase 1 inventory. If we start to get a feeling part-way through that we have misjudged, it would be nice to have a little bit of flexibility during that phase. Afterwards it would be possible for us to come back.

Miss Stephenson: It might be necessary then to triple item 3 under that.

Mr. R. F. Johnston: Yes.

Dr. Stoddart: What you are suggesting would be fine with us. We looked at what that firm was about to charge the committee for staffing the entire process. They thought that if they were going to do it for that price, they might be able to do the inventory for about that price; but that may not be the case. We have never met them.

If you want to increase the budget, that makes us feel better about the enterprise, but we do not want to be the source of that increase.

15:30

Mr. Chairman: Is that a motion?

Miss Stephenson: No. The addition of the contingency to the level of \$75,000 for this, knowing full well that we may have to do something at the end of phase 1 as well, depending on what comes out of the examination of the inventory and the material that is presented to us at the end of phase 1.

Mr. R. F. Johnston: I want to clarify a couple of things. You are adding \$6,100 to make it \$75,000. We are running over our fiscal year. For our purposes, this is a budget the parameters of which are known to our architects as to what we are going to be spending. As far as the board goes, it will have to be divided up and it will be the research component of our money for this purpose during this fiscal year. There will be a hearing process for which we will need a fair amount of money at some point during the January-March period. Then there will be another budget that will include part of this plus the next stage of whatever it is we are doing as a committee. I want to remind you of that. For our purposes, we should approve the \$75,000 today so we know what general, overall research package we can presume at this point. However, that is not the same as the budget we will be presenting to the board through the clerk and the chair.

Miss Stephenson: Unhappily, Richard, the second portion of this, as I understand it, is intended to cover the full year of a research adviser's activity. You are suggesting that what we are doing is approving the preliminary budget to March 31, 1987, for this committee at present.

Mr. R. F. Johnston: I am saying that may be all the board will let us do. We can argue for the whole package.

Miss Stephenson: At this point we have not even looked at what might be necessary in terms of public hearings.

Mr. R. F. Johnston: That is a separate item altogether we would not apply for until we went for supplementary estimates, I presume at the end of the year in December.

Clerk of the Committee: Whenever the committee decides to start public hearings, we will decide how long we need and how much that will cost. We would then go to the board for the supplementary. If you decide to sit in January and February for public hearings, we would go in January for a supplementary. You are quite right that in most cases the board will approve for the fiscal year ending March 31, but because this committee has a mandate of a year, we may be able to argue successfully that we need to have the whole package approved.

Mr. R. F. Johnston: At least for this.

Clerk of the Committee: Then what we spend until March 31 will be the amount needed.

Mr. Chairman: I want to be clear because I am the person who has to go. Are you suggesting there should be something in the budget saying that it is simply to take us through phase 1?

Mr. R. F. Johnston: No.

Mr. D. S. Cooke: Just take it to the Board of Internal Economy.

Clerk of the Committee: This is the budget to the beginning of August 1987.

Mr. R. F. Johnston: This is our research budget for the--

Clerk of the Committee: For the duration.

Mr. D. S. Cooke: We need the board to approve it in principle but it will only budget for the fiscal year 1986-87. I move approval of the amendment of the \$6,100 for contingency.

Mr. Chairman: So that I can get back to this again, our supplementary will be for the purposes of covering the cost of the witnesses, the hearings themselves.

Mr. D. S. Cooke: Can we get what months or weeks we are going to be able to sit?

Mr. Chairman: Mr. D. S. Cooke moves that a supplementary budget in the amount of \$75,000 be approved and that the chairman be authorized to present it to the Board of Internal Economy.

Mr. D. S. Cooke: That is exactly what I said.

Miss Stephenson: I am delighted that Mr. Cooke speaks so definitively.

Mr. Chairman: All those in favour will please say "aye."

All those opposed will please say "nay."

In my opinion the ayes have it.

Motion agreed to.

Mr. Chairman: Let it be recorded that Mr. Sargent opposed it. What would he rather go to?

Miss Stephenson: He wanted \$100,000.

Mr. D. S. Cooke: Why do you not write a cheque for \$25,000?

Miss Stephenson: Sell your car.

Mr. Chairman: Are there any further items?

Dr. Stoddart: We have no further items for the committee as a whole. Thank you for your input to the research process.

Clerk of the Committee: For the record, I would like an official motion that subject to the approval of these funds, the committee does want to retain Greg Stoddart and Roberta Labelle.

Mr. R. F. Johnston: I am sure I just moved that.

Motion agreed to.

Clerk of the Committee: The other thing I need is some discussion about the week of September 15.

Mr. Chairman: We said we would leave that.

Mr. R. F. Johnston: I think the presumption was we did not need that.

Miss Stephenson: When we will need it is the point. We will need it when our research advisers have had an opportunity to carry out their preliminary work and discussions with Ms. Fooks. Is September 15 the appropriate time, or is that too soon?

Dr. Stoddart: I do not think we can tell you that today. We will get going on things as fast as possible, but until we review some of these documents that are--

Miss Stephenson: Floating.

Dr. Stoddart: Yes. I would like to be able to tell you that today, but I do not think we can.

Mr. R. F. Johnston: I would like to be clear. I am not concerned about the committee meeting because I am willing to have those preliminary decisions about hiring and on what basis made by our steering committee, within the parameters of this budget we have just approved, and not have to bring the entire committee back at that stage.

Miss Stephenson: You are willing to do that. Mr. Cooke's suggestion was that the entire committee should be involved in making the decision about whether the researchers recommended by the research advisers should be employed to carry out the research.

Mr. D. S. Cooke: If we are going to make any decisions on narrowing the scope or decisions that will ultimately affect the final report, then I think the full committee should be looking at it.

Miss Stephenson: The final report?

Mr. D. S. Cooke: Or the interim report, but I understand the interim report is going to be fairly broad. I do not want us to make policy decisions about the scope of the report. Everyone should be part of that discussion.

Miss Stephenson: I did not understand that. When you responded so rapidly after the statement that the recommendation would be made to the steering committee, I thought you were concerned that the committee had to be involved in making the decisions about which group would be employed.

Mr. D. S. Cooke: I do not mind either way. It does not bother me. I do not assume we are going to take your recommendation.

Mr. Chairman: Do other members think there should be a full committee meeting?

Mr. R. F. Johnston: It is an important decision. At this stage, a number of us have not met with the other group. Our research architects and staff will now be able to do that and come back with a recommendation to our

steering committee, which I will be willing to accept at this stage.

Miss Stephenson: So would I, as far as that goes.

Mr. Chairman: Conceivably it will take one day. Let us pick a day in the week of September 15.

Miss Stephenson: No, because Dr. Stoddart and Ms. Labelle will not be ready at that point.

Mr. R. F. Johnston: Without knowing now, it is easier to pull together a steering committee than all of us.

Mr. D. S. Cooke: We will meet at the call of the chair.

Mr. Chairman: The call of the chair also requires that we get the meeting room and time approved.

Mr. D. S. Cooke: The steering committee can meet. That is not on the record.

Mr. Chairman: Then you want the full committee?

Miss Stephenson: No.

Mr. R. F. Johnston: Not unless others do. I have not heard from your colleague. Where do you stand, Mr. Reycraft?

Mr. Reycraft: We are quite prepared to have the steering committee be given the responsibility for approving the research assignments.

Mr. Chairman: Dr. Stoddart, will you contact the steering committee when you are ready to do that?

Dr. Stoddart: Certainly. I presume that for the next few days we will be in almost daily contact with Ms. Fooks and Mrs. Deller.

Mr. Chairman: The clerk, or whomever does it, can notify everyone that we do not meet the week of September 15. Is everybody in agreement with that? We do not need a motion or anything for that, do we? We are not meeting tomorrow.

The committee adjourned at 3:37 p.m.

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SELECT COMMITTEE ON HEALTH

COMMERCIALIZATION OF HUMAN SERVICES

WEDNESDAY, JANUARY 21, 1987



SELECT COMMITTEE ON HEALTH

CHAIRMAN: Callahan, R. V. (Brampton L)
Andrewes, P. W. (Lincoln PC)
Baetz, R. C. (Ottawa West PC)
Caplan, E. (Oriole L)
Cooke, D. S. (Windsor-Riverside NDP)
Hart, C. E. (York East L)
Henderson, D. J. (Humber L)
Johnston, R. F. (Scarborough West NDP)
Reycraft, D. R. (Middlesex L)
Stephenson, B. M. (York Mills PC)
Turner, J. M. (Peterborough PC)

Substitutions:

Knight, D. S. (Halton-Burlington L) for Mr. Reycraft
Pierce, F. J. (Rainy River PC) for Mr. Baetz
Sheppard, H. N. (Northumberland PC) for Mr. Turner

Clerk: Deller, D.

Clerk's Assistant: Waterston, M., Legislative Page

Witnesses:

From the Office of the Assembly:

Fooks, C., Research Officer, Legislative Research Service, Legislative
Library, Research and Information Services

From Research Innovations:

Hannant, J., Research Director

LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON HEALTH

Wednesday, January 21, 1987

The committee met at 3:16 p.m. in committee room 1.

COMMERCIALIZATION OF HUMAN SERVICES

Mr. Chairman: I recognize a quorum. You have an agenda before you. Are there any comments from any members of the committee before we plough into our agenda?

Mr. D. S. Cooke: Should we deal with how we are going to deal with Mr. Pierce's bill before we get into any part of our agenda?

Mr. Chairman: That is Bill 52.

Mr. D. S. Cooke: Right.

Mr. Chairman: There are three ladies here, perhaps more, who have some interest in this. What do you have to say, Mr. Cooke?

Mr. D. S. Cooke: I just said I thought we should deal with it. I would like to listen to everybody else. You know me.

Mr. Chairman: Yes. The only comment I would make at the outset is that, without putting any caveats on anybody on how much time we spend on this, we have a significant agenda to go through. We have been allocated less time than we thought by the House leaders, so I cite that before we get into any discussion on this.

Mr. Pierce: If I might, the bill was first presented to the select committee in early November 1985. At that time there was nothing on the agenda for the select committee on health. It has not been dealt with, and we are now into January 1987. The agenda of the select committee now appears to be full for the amount of time that is available to it. I wonder whether this bill should take priority over any other items that have appeared on the agenda, since it was referred to the select committee on health.

There are a number of interested people throughout Ontario and, to go beyond that, throughout Canada, who are very concerned about the effects of the reference of the bill. It has sat for some time. I realize that the route the bill has gone to get here is not a common one, but it is with this committee. I look for the approval of the committee to accept, debate and make recommendations on it as well as to hold public hearings so that the interested parties in the general public will have an opportunity to provide some background information on why the bill was presented in the first place.

With all respect to the committee, and recognizing the schedule of the Legislature and the time constraints we are all under, I still feel that this bill deserves more recognition than being put at the bottom of the agenda of the select committee on health, unless--and I am prepared to say "unless"--the committee can guarantee that it will go to another committee and get top priority.

Mr. Chairman: You have been around here long enough to know that we cannot do that, or at least that is my understanding. It would have to go back to the House leaders and they would have to make that decision.

Mr. D. S. Cooke: The government House leader's assistant has chatted with you; I talked to her as well. The recommendation, I gather, from Mr. Nixon is that, if we are going to refer the bill, we not leave it in the hands of the House leaders but we will refer it, and there is a guarantee that it will be referred to the appropriate committee, the standing committee on social development.

I think, Mr. Pierce, to be completely fair, if one looks at the history of this committee, when the bill was referred to the committee, the committee was not established. Everybody knew there was going to be a committee, but there were no terms of reference, there was no membership of the committee and there was not an operating committee.

This committee really began to operate only at the end of the spring session. On the last day, the terms of reference were passed, and the committee then met to look at some parameters and directions for our researchers, after a fairly lengthy process of hiring our researchers. Therefore, it is not entirely fair to say that this committee has been around since whenever in 1985.

I think it would also be fair to say it was inappropriate that this bill was ever referred to a select committee, whoever's mistake it is. The entire House agreed the day your bill was before the House that it be referred to this committee, and somebody out of all of us who were in the House should have spoken up and said that this was an inappropriate committee; but it got through--a mistake on all our parts.

I think there is a consensus. It was passed in the House. It obviously received support from all three parties. I gather the Ministry of Health has some suggestions on how to improve the bill, and it is supportive. If some improvements are made and some expansions, all it needs to do is to bring forward some amendments when the bill is dealt with.

I would simply suggest that if all of us--many of us who are on the social development committee for health care purposes as well--could just agree to refer it to the House and get it to the social development committee, the chairman of the social development committee is here and I think there is a consensus that it can be dealt with in much shorter order than it will be dealt with in this committee, Mr. Pierce. We all want the bill passed. Let us start from that premise.

Mr. Knight: I have just an observation on the suggestion that the bill perhaps was not appropriately referred to this particular committee.

I understand that with a select committee, unlike a standing committee, the agenda, although it can be worked out according to the committee's wishes, still has to come within the framework of the terms of reference that the Legislature provides for the select committee.

I suppose, as a point of clarification, perhaps we could clarify whether, within the terms we were given, the inclusion of--have those included, I suspect; perhaps it would not--and therefore our discussion of it does become somewhat superfluous, and the suggestion that it be referred to another committee would be the best way to handle it, if we can get the House leaders to agree.

Mr. Chairman: I will ask the clerk to respond to that, Mr. Knight.

Clerk of the Committee: The bill does not in fact fit within the committee's specific terms of reference. However, because the bill was referred to the committee, that gives it authority to consider it.

Mr. R. F. Johnston: We had a tête-à-tête among the major players on the standing committee on social development yesterday to try to see how we could deal with this. I concur with what Mr. Cooke is saying: It looks as though it could be dealt with fairly expeditiously. I am not sure what the government wants to change, but the minister did not give me the understanding that it was of such major consequence that it would take an awful lot of time.

Our schedule at the moment is fairly full until February 9, but from that point until we rise, we have no estimates. We would have bills such as the Nursing Homes Act that might be forthcoming, but if it is the sort of thing that can be dealt with in a day or two, we could deal with it then. Even if it were within the terms of reference of this committee to deal with it, that would be much sooner.

If there is any way we can add instruction--I do not know whether we can--back to the House in our report that we think this is better dealt with by the social development committee, and if we wish to say something about its being dealt with expeditiously by the social development committee, that would be fine, too. I think the members of that committee would have no problem with it.

Mr. Andrewes: I do not want to prolong the discussion. I agree with basically everything everyone has said. We are looking for a way of expediting this bill.

Mr. Chairman: Mr. Andrewes moves that the committee report the bill back to the House with the recommendation that it go to the standing committee on social development to be dealt with expeditiously.

Any further speakers? Being the new boy on the block, I inquire of the clerk, do we have the authority to do what Mr. Andrewes suggests?

Mr. R. F. Johnston: We can do it; they do not have to accept it.

Miss Stephenson: They may not accept it, but we can certainly make the recommendation.

Clerk of the Committee: You can send the bill back with whatever recommendations you wish.

Mr. D. S. Cooke: Both Mr. Andrewes and I will be at the House leaders' meeting tomorrow morning and we will both make sure we raise it.

Mr. Pierce: Is that almost a two-to-one thing?

Mr. D. S. Cooke: No.

Mr. Pierce: I appreciate the interest of the select committee on health and that the members want to see the bill moved as quickly as possible to get the attention it deserves. I have no objection to having it referred to the social development committee. I am prepared to accept the comments of the chairman of the social development committee that it would get the attention

it deserves and be rapidly moved up on the agenda so that it could be dealt with before the House adjourns the winter sitting.

If it is required, I would be prepared to second the motion of Mr. Andrewes to have it referred back to the House for further direction.

Mr. Chairman: You have somewhat enhanced Mr. Andrewes's motion, but perhaps he is content that those embellishments are attached. All right? Are there any further questions by members of committee?

Motion agreed to.

Mr. D. S. Cooke: Now get out of here.

Miss Stephenson: What is the precise recommendation?

Clerk of the Committee: That the committee refer Bill 52 back to the House and recommend to the House leaders that it be referred to the standing committee on social development.

Miss Stephenson: For expeditious--

Clerk of the Committee: For expeditious consideration.

Mr. Chairman: Perhaps rather than let anyone leave who might be here--

Mr. R. F. Johnston: We should let them go if they want.

Mr. Chairman: I hope what we have done is clear. I suppose Mr. Pierce, who appears to be leaving, can give you a greater explanation. Are you leaving the committee?

Mr. Pierce: Yes, I am.

Mr. Chairman: Perhaps you would be good enough to answer any questions.

Mr. Pierce: I have estimates on the Ministry of Northern Development and Mines with the Premier (Mr. Peterson). That does not happen every day of the week, so we are going to take advantage of the opportunity to question him.

Mr. D. S. Cooke: Neither does this.

Mr. Pierce: That is right.

Mr. D. S. Cooke: Where are your priorities?

Mr. Pierce: You can judge my priorities by the fact that I am here rather than with the Premier. You can take that as you like it, Mr. Chairman.

Mr. Chairman: I do not take anything any way. I am totally impartial as chairman of this committee.

Mr. Pierce: On that sour note, I will leave.

Miss Stephenson: It is not sour; it is hilarious.

Mr. Chairman: Before we proceed, the clerk has indicated she wishes to make a few comments.

Clerk of the Committee: You probably have noticed that the consultants the committee hired, Stoddart and Labelle, are not here yet. Roberta Labelle will be here later in the afternoon, but they both had prior commitments. They had a bit of trouble trying to juggle their schedules.

Mr. Chairman: Our research officer wishes to proceed with her portion of the matter in camera. We need five minutes in camera. Perhaps I could have a motion to that effect.

Miss Stephenson moves that the committee continue in camera for five minutes.

Motion agreed to.

The committee continued in camera at 3:30 p.m.

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Mr. Chairman: We have gone through a full section rather than otherwise. Unless there is something terribly significant, I urge the members to co-operate as best they can in that regard.

Ms. Fooks: The index will show you how we have grouped programs. Because of the time, I am proposing to work backwards and start with those programs that have the most for-profit activity and see how our time goes, working down. This means that for the Ministry of Health, we would start with laboratory services which is tab 11-1.

I need some direction from the committee on how much explanation it wants about the operation of the program itself. Each program has fact sheets that explain the legislation and the clientele and describe the program, the number of facilities, the licensing procedures, inspection procedures where they are appropriate, expenditures, costs, corporate concentration, the types of charges, funding and service statistics. Can I get some direction from the committee on how much detail it would like about the actual programs and how much it would like to focus on the numbers?

Mr. Chairman: I am sorry; I must be on the wrong--

Ms. Fooks: I can focus strictly on the numbers or I can go through what is required for a licence, if members wish.

Miss Stephenson: One of the facts I think may be important is the number of new licences issued by the ministry within the last five years. It is my understanding it is zilch.

Ms. Fooks: I will quickly go through this. For laboratory services, there are a total of 410 labs and 276 specimen collection centres that do not operate as labs. They collect the samples, but they do not operate as full labs. Of this, there are 12 public health labs which is 2.9 per cent of the total. There are 223 hospital labs which is 54.3 per cent and one lab in a health service organization in Sault Ste. Marie for a total of 224. There are 27 specimen collection centres which is 9.8 per cent; 175 private, for-profit

labs which is 42.4 per cent; and 249 specimen collection centres which is 90.2 per cent.

The activity is basically between hospital labs and private labs. The hospital labs we have included in the not-for-profit, private activity rather than public because the hospitals are not actually owned by the government. Do you want me to go through the licensing requirements? Is that necessary?

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Mr. D. S. Cooke: At some point, I am going to have to read this.

Miss Stephenson: The licensing requirements were established about a decade and a half ago. They have not changed and no new licences have been issued.

Mr. R. F. Johnston: For now, move on.

Ms. Fooks: Total expenditures there consist of \$538 million; 59 per cent of all expenditures are going to the hospital labs and 38.4 per cent of all expenditures are going to private labs and physicians who do testing in their offices.

Probably what is significant in all this is table 11-3, "Top 10 Laboratory Chains Percentage Share of Total Volume of Services and OHIP Payments." This is in rank order. This is a list of the top 10 commercial for-profit laboratories in Ontario. The rank on the left-hand side is by volume of service; that is, the number of tests these labs perform. The rank on the right-hand side is by Ontario health insurance plan payment; that is, by how money they receive from OHIP. I am not going to read through all these labs.

If you go through the columns, ownership is the name of the lab and owning is what they actually own. Therefore, we have the number of labs and the number of specimen collection centres that each company owns; the percentage of the total; the number of tests they perform and the percentage of the total; how much money they receive from OHIP and the percentage of the total.

If you drop down after the first five labs, you can see that by volume of service, the top five laboratory corporations in the province perform 17.3 per cent of all tests and receive 20.3 per cent of all expenditures. The top 10, if you drop down to the bottom of the table, perform 23.2 per cent of all tests and receive 26.9 per cent of all expenditures. That is of all tests done in the province.

When you separate the private for-profit sector from the rest, you drop down to the top 10 per cent as a percentage of private for-profit total. We are looking at the same 10 companies within the private for-profit sector rather than the whole sector. Those top 10 companies perform 69.8 per cent of all tests in the private sector and receive 70 per cent of all expenditures that go to those private for-profit labs. The story is the top 10 companies are performing most of the business and receiving most of the money.

That is one of the more highly concentrated areas. Is that clear?

Mr. R. F. Johnston: Locations?

Ms. Fooks: Locations of the labs?

Mr. Chairman: This is even though there seems to be an equal distribution between the not-for-profit, private, and the private for profit?

Ms. Fooks: That is right; in the whole picture, it is about half.

Mr. Chairman: They are almost equal, 223 versus 224 and the private sector is doing the bulk.

Ms. Fooks: When you look at just the private sector, the top 10 companies are the main players.

Miss Stephenson: The only truly public laboratory in Ontario is the public health laboratory. There are not many of those and their roles are severely limited. They have precious little to do with the day-to-day laboratory service provided for patients, either as inpatients or outpatients.

Ms. Fooks: If you look at the first fact sheet, there are 12 public health labs in the 2.9 per cent of the total. That is a very small amount. This is why we were trying to be careful with our definitions. Often our information was given to us in terms of public and private, and the public was not really public; it was private not-for-profit. We are going to be reiterating those words often.

Behind the table, just for interest, the ministry has sent an application form for applying for a licence. You can get a sense of the kind of information that they request when someone applies for a licence. Those are the questions they answer.

Miss Stephenson: Can you find out when they last issued a new licence? I think it was at least a decade ago.

Ms. Fooks: Off the top of my head I cannot remember. However, I can certainly get you that date.

Mr. R. F. Johnston: You were raising it before.

Miss Stephenson: It is a very long time. There has been transfer of licences.

Mr. R. F. Johnston: Yes.

Ms. Fooks: The next program is the approved homes program. This is section 12-1. This is one of the programs you may wish to disregard in this category. It is a program provided for residents of psychiatric facilities who have not been discharged from the facility. They are still under the care of a psychiatric facility. However, it is felt they could benefit from a more community-like living arrangement. Therefore, the approved home is under the supervision of the psychiatric institution, but it is owned by private individuals who are paid a certain amount of money per person they care for. That is why we have put it in this category. You may wish to take this one out. It is up to you.

Mr. Chairman: I do not understand that. Maybe think the other members do. Why would we take it out?

Ms. Fooks: I will go over it again. This is a category where we have

put private individuals who are being paid a fee to look after people. We have put them in the private-for-profit category. If the committee does not feel this is appropriate, we can certainly take it out. This is the top category, where there is more than 45 per cent for-profit activity. In this case, depending how you define "approved home"--if you are defining "approved home" as a for-profit private individual, it is 100 per cent for-profit activity. If you are going to define it differently, then it is not. We do not have to do it today, but it is something I point out to you as to whether you want to keep it in this group. It is basically a home that is under the supervision of a psychiatric institution. The owners of the home look after the residents and they are paid a fee for service to do so.

Miss Stephenson: The question is, by whom?

Ms. Fooks: Who pays them?

Miss Stephenson: Who pays them?

Ms. Fooks: The money is directed through the budget of the hospital.

Miss Stephenson: In actual fact they are paid by the psychiatric institution. They are not only selected by the psychiatric institution; the money is also provided through the psychiatric institution.

Ms. Fooks: It is included in their budget.

Miss Stephenson: It is within their budget and therefore administered by the institution rather than by the ministry.

Ms. Fooks: Right.

Mr. Sheppard: Would they be paid so much a day?

Ms. Fooks: Yes.

Mr. Chairman: They get \$20.88 per day per patient.

Ms. Fooks: Per day.

Mr. R. F. Johnston: I think they have to be maintained in this category. Often in approved homes you have many more than one or two people involved. They are as big as some nursing homes in some cases. That per diem is something that if you separate it out would be a mistake. That is my own opinion at this stage.

Ms. Fooks: Okay. On the second page of that section you have the distribution of homes and beds. You can see from the licensed capacity and the actual capacity, the homes are not full. There are only 87 residents in this program at the moment.

Miss Stephenson: Are there any more than five residents in one single home?

Ms. Fooks: What we do not have is the number of beds for each individual home.

Miss Stephenson: That is right.

Mr. D. S. Cooke: For example, in Brockville, where there are five homes and there are 34 licensed beds, there has to be somewhat more than five even though right now, the actual occupancy is only 10. They are licensed for much more.

Ms. Fooks: We can certainly ask if the ministry can give us that information, if you would like.

Interjection: Here is Whitby--

Mr. R. F. Johnston: In Whitby, there is one home and there are 12 licensed beds.

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Mr. Sheppard: Is it unusual to have 34 licensed beds with only 10 occupants?

Ms. Fooks: We would have to get the ministry to answer that question.

Mr. Chairman: It is usually the reverse; they have more applicants than licensed beds.

Mr. Sheppard: That is right. That is why I asked the question. You cannot answer it. We have to ask somebody from the ministry.

Mr. R. F. Johnston: The policy on this has changed a fair amount over the last number of years. For a while, approved homes were very much up to maximum capacity, but there has been a move away from using them.

Ms. Fooks: This is one of the areas where we were told historical information was not available. This is what we have been given for this particular program. As I say, you might want to think about where you would like to place this program. At the moment we have it here, but we can certainly move it.

The next one is homes for special care, tab 13-1. There is a total of 467 homes for special care. Of those, 211 are nursing homes that also have licences as homes for special care--they are not separate facilities; they are within nursing homes--and 256 are residential homes. Of the total of 467, one home has been defined as public sector, 10 as private not-for-profit and 456 as private for-profit, which is 97.6 per cent of the total number of facilities. This is very much a for-profit activity.

Miss Stephenson: Where is the public sector home?

Ms. Fooks: I do not know. They just gave us numbers.

I might go through the licensing procedures for this one because they are somewhat complicated. To get a nursing home homes-for-special-care licence, the home must already have a valid licence under the Nursing Homes Act. The licences for the homes-for-special-care component are granted on the following conditions: a demonstrated need for the home; the home meets with municipal zoning requirements and fire safety and environmental health requirements of the Homes For Special Care Act; the operator and the home must be recommended by the administrator of the relevant psychiatric hospital. The people who are coming are being discharged from a psychiatric hospital or are coming from regional centres for the developmentally handicapped. In this

program, you have two kinds of clients, people who have a history of mental illness and the developmentally handicapped.

The inspection procedures are fairly similar to those under the Nursing Homes Act. Fire safety inspection is done by the fire marshal's office in smaller communities and by the municipal fire departments in larger communities. Environmental inspections are conducted by the public health units.

We were able to get some numbers on violations of the act, which are at the bottom of the page. Unfortunately, they could not break down the nursing home component on an annual basis. We were given numbers for two years instead of only 1986, so that skews those numbers a little bit when you are looking at them. There have been no prosecutions of the residential homes for special care. There have been prosecutions for the nursing homes part of the homes for special care, and they are listed in table 2, which is behind tab 13-2. This is for 1986, a total number of 13 homes and 58 violations. They are all in court so there have not been any results.

Where we can, we have always asked to have expenditure data broken down into what is going to the for-profit sector and what is going to the not-for-profit sector. In this case, they were able to give us some of that. Of the total expenditures, 1.3 per cent went to private not-for-profit nursing homes, 0.8 per cent went to private not-for-profit residential care homes, 98.7 per cent went to private for-profit nursing homes and 99.2 per cent went to private for-profit residential care homes.

Again, that tends to jibe with the numbers of facilities we were given. Most of the money is going to the private for-profit sector.

We asked for operating costs, capital costs and profit margins, and we were told they were not available.

I will get you to turn to table 1, which is behind 13-2. This is a breakdown of the ownership of these homes by type of licence. We might as well focus on the private for-profit sector. A total of 179 homes are owned by corporations, which is 38.3 per cent of the total; 16 homes--and this is just the nursing homes--are owned by limited partnerships, which is 3.4 per cent of the total; eight homes are individual ownerships, which is 1.7 per cent. That gives you a total of 203 nursing homes/homes for special care owned by the private for-profit sector, which is 43.5 per cent of the total.

When you move to the residential care sector, you have a total of 253, which is 54.2 per cent of the total. That takes the number we have for total facilities and breaks it down by the type of ownership, the licence of the home, for both nursing homes and residential care. Again, the majority are in the private for-profit sector.

As a matter of interest, table 3 has a breakdown of the number of residents in the homes as of August 1986. It is broken down by nursing homes and residential care homes. There are 1,262 developmentally handicapped and 2,286 former psychiatric patients in the nursing homes; 423 developmentally handicapped and 1,607 former psychiatric patients in the residential care homes.

Are there questions on that one? We are rushing through these numbers and it gets a little confusing.

Mr. D. S. Cooke: You made it all perfectly clear.

Mr. Sheppard: In table 2 it says there are violations at St. Joseph Nursing Home. Where is that nursing home?

Ms. Fooks: I could not tell you off the top of my head. They gave us a list of the homes without any locations. I can certainly find out.

Mr. Sheppard: Fine, thank you.

Ms. Fooks: Tell me if I am moving through this too quickly.

Mr. Chairman: Michael seems to think it is in his riding.

Mr. Waterston: It is in Guelph.

Mr. Chairman: It is amazing the sources of information we have in this Legislature. You have just earned your salary for the entire session, Michael.

Miss Stephenson: Such as it is.

Ms. Fooks: Shall we move on to nursing homes?

Mr. Chairman: At what tab are we?

Ms. Fooks: We are at tab 14-1. There are 332 homes. Three of them are municipally owned, 0.9 per cent. Twenty-seven are in the not-for-profit category: two are owned by Indian bands, eight are owned by hospitals and 17 are owned by charitable and religious groups, for a total of 8.1 per cent. Three hundred and two, which is 91 per cent of the facilities, are in the private for-profit sector: 147 are owned by individuals and what are classified as minor corporations, which own up to two homes, and the rest are owned by corporations.

Again, the inspection numbers we were given were for a two-year period, so those numbers are slightly skewed. Those are not just the relicensing inspections; they are also inspections coming from complaints by outside groups.

The best thing to look at is the table behind 14-3.

Miss Stephenson: Is that table 1?

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Ms. Fooks: Yes, start with table 1. These are complaints against nursing homes. Again, it is a two-year period. This is not to be confused with inspection numbers or violations. These are complaints that are coming from residents in the home, families of the residents or outside groups, mainly concerned friends, and it is broken down by type of ownership.

The first category, then, is the number of homes within each type of ownership that had complaints laid against them, and then the number of complaints: corporations, 145 homes, and then--I am not going to read this--there is a breakdown for each kind of complaint. For limited partnership, seven homes had complaints laid against them, and the number goes across. For individually owned homes, five homes had complaints laid against

them. Nonprofit--that should read "Not-for-profit"; we are not being consistent here--had 10 homes with complaints laid against them.

We are also told that, following from these complaints, information has been sworn against two homes in 1986 on the basis of complaints. There were 13 charges, and both cases are in the courts. The bottom part of the page, which I am not going to read through, is just a breakdown of what has happened to those charges.

Table 2 is a listing of the 25 chain operators owning nursing homes in the province as of December 1, 1986. The rank is down the side. We ranked these in terms of number of beds rather than the number of homes, because the number of homes can be a little bit misleading. If somebody owns maybe three homes, he could still own 900 or 1,000 beds if he has large homes, so the ranking has been done by number of beds.

The top five companies own 20 per cent of all homes, 31 per cent of all beds. The top 10 companies own 28.9 per cent of all homes and 43.9 per cent of all beds. All of the 25 chain operators together own 48.2 per cent of all homes and 61.4 per cent of all beds.

As I have said in the memo, my unit has done some searches on the ownership of these companies, because the Ministry of Health can tell us only who the president and director of a company are. Behind tab 14-4 is ownership information on the top 10. It became a very time-consuming thing to do, so I have included only the top 10, which I am not going to go through; that is just as a matter of interest for members of the committee. However, if anybody would like information on the other 15 chain operators, it is available. We also have information on the nonchain but corporate owners, which is also available. It is not included in here, but if you want it, it is there.

Mr. R. F. Johnston: In what sort of form would that be?

Ms. Fooks: The same form as this. This document was getting very bulky.

Mr. R. F. Johnston: Yes. I would be interested in seeing it.

Ms. Fooks: Okay. If I can just recap for a moment, we have just looked at the programs where there is greater than 45 per cent for-profit activity. We have looked at labs, approved homes, if the committee wishes to keep them in this category, homes for special care and nursing homes.

I know we have gone through this really quickly, and it is a lot of information to digest, but I would be happy to take questions, if there are some.

Mr. Chairman: Everybody seems to be coming along quite nicely; no questions.

Mr. R. F. Johnston: None spring to mind right at the moment. None of these areas, except for the grouped homes, is an area where you have had problems receiving historical documentation. That was the only area where you had any trouble.

Ms. Fooks: We had some trouble with nursing homes. Tomorrow Joan Hannant will be giving you sort of more of an overall picture of this stuff; and where possible, there will be trended data. We did not get trended data on nursing homes.

Mr. D. S. Cooke: Can I just ask you a question? I have tried to add up my figures here correctly. In your table 2, it says Versa-Care Ltd., ownership of number of beds, 4.8 per cent. Then when you get to the actual page on Versa-Care, it says 11.8 per cent.

Mr. Chairman: Is everybody with Mr. Cooke on the location of what he is looking at?

Mr. D. S. Cooke: It is the table you went through, and then on the page that outlines Versa-Care it says 11.8 per cent.

Ms. Fooks: It is a typo. It should be 11.8 per cent. I will check it for sure and let you know tomorrow.

Mr. D. S. Cooke: That will change all the totals too.

Ms. Fooks: No; it is probably just a typo.

Mr. D. S. Cooke: I added it up, and that is why I came up with a higher number.

Ms. Fooks: I will check it and give it to you tomorrow.

Miss Stephenson: If indeed 1,424 is 11.8 per cent, then surely Diversicare at 1,374 cannot be 4.6 per cent.

Ms. Fooks: No. Sorry; the typo is in the written-- The table is right.

Miss Stephenson: It is 4.8 per cent, not 11.8 per cent.

Ms. Fooks: Right.

Mr. D. S. Cooke: Oh, okay.

Ms. Fooks: The table is correct, but I will doublecheck it just to make sure.

We can do two things. We can either drop down a category in the Ministry of Health or do the same category in the Ministry of Community and Social Services. It is up to the committee.

Mr. R. F. Johnston: Let us do the same category in the Ministry of Community and Social Services.

Ms. Fooks: Okay.

Mr. Chairman: Does anybody have a better suggestion? We will do the same category in the Ministry of Community and Social Services.

Ms. Fooks: Okay. We start with tab 30. Again, the programs we are going to go through are programs that have greater than 45 per cent for-profit activity, starting with municipal hostels. There is an exception to every rule, and we have a real problem with this program in that the most up-to-date information we could get from the ministry was 1981 data. Apparently, hostels are one of the programs where they do not really keep statistical information. The only thing they keep--at least, this is what they have told us--is numbers of subsidized people. They do not actually keep the number of beds and the number of homes. However, they are--

Miss Stephenson: How do you keep track of the subsidized people? Do they all have counters on them and they tick them off as they come in, or what?

Ms. Fooks: All I can tell you is what they have told me, and that is what they have told us.

Mr. R. F. Johnston: I think this is an area for follow-up with the minister, for a couple of reasons. One is that there has been a recent survey of hostel services again, as I understand it, which should have updated information for us that should be available to us.

Ms. Fooks: That, they have told us, is not ready yet; it is not going to be ready until the spring of 1987. We asked whether it would be possible to have some of that information ahead of time, but it was not.

Mr. Chairman: Could it be that the reason they do not have that information is that the hostels are accountable to the municipalities rather than directly to the province? I guess the province just flows the money through the municipalities.

Ms. Fooks: That is right.

Mr. Chairman: I do not know whether that was the case in 1981. In 1981 and earlier, was it not done directly by the province?

Mr. R. F. Johnston: It was all done under the General Welfare Assistance Act.

Miss Stephenson: That is right, and in some instances it was done directly; in other instances it was through the municipality, depending on whether the municipality wanted to be involved or not.

Ms. Fooks: We asked for total number of facilities and total number of beds. The response we got was that this information was not available. The only thing they had statistics on was the number of people for whom service was purchased under GWA. However, they said they would have a better idea of those numbers when the survey was completed in 1987.

The only numbers we did get from them--and I stress that they were based on a 1981 survey--are those numbers that you see there under "Number of Facilities." The percentages were two per cent municipally owned, 28 per cent charitably owned and 70 per cent in the private for-profit sector. I do not know whether the committee is comfortable putting this program in this category on the basis of percentages from 1981 or whether you would just like to leave it for the moment. It is up to the committee.

Mr. R. F. Johnston: If I might, Mr. Chairman, I think we should leave it in the category. I am not aware--

Miss Stephenson: It is going to be over 45 per cent anyway.

Mr. Chairman: I do not think it has gotten better.

Miss Stephenson: It may have a little bit, but it has not gone below 45 per cent, I am sure.

Mr. R. F. Johnston: The statistics that these are based on for 1981, are these the ones that were done on the report by--what is his name?

Ms. Fooks: Gordon Guyatt? I do not know.

Mr. R. F. Johnston: --which represented the standing committee on social development back when we were dealing with abuse.

Ms. Fooks: I think it was, actually, because I believe we asked for that report in August.

Those are the only percentages we have on this program, unfortunately, because it looks as though it is one of the areas where the for-profit sector is fairly active, but I guess we will keep it there for the moment.

Children's boarding homes and extended family homes: This is a program that provides boarding home care to wards of a children's aid society. The extended family homes, which are a component of the boarding home care, are the same type of care that is operated in a slightly smaller facility, so it is residential care provided to wards of a children's aid society.

There are a total of 189 boarding homes and 129 extended family units. Within that there are 33 chain operators, who own 110 boarding homes, which is a total of 58.2 per cent. Because generally the extended family home is run by the boarding home owner, the same 33 chain operators own 123 extended family units, which is 95.3 per cent of the total.

There are 79 individual operators who own the 79 remaining homes, which is 41.8 per cent of the total, and the six extended family units, which is 4.7 per cent of the total. This individual operator category is another area where you may not wish to put them in this particular sector.

Mr. Chairman: I am having difficulty distinguishing between boarding homes and extended family units.

Ms. Fooks: They both provide the same kind of care. It is residential care for wards of a children's aid society. Boarding homes are bigger. That is really the only difference.

If we can flip to the second page under beds, this will give you the percentages for the beds. There are a total of 1,512 beds within the 189 homes; 799 are owned by the 33 multiple operators, which is 52.8 per cent; 713 are owned by the 79 individual operators, which is 47.2 per cent.

There are a total of 490 extended family home beds; 464 are owned by the 33 operators, which is 94.7 per cent, and 26 are owned by the 79 individual operators, which is 5.3 per cent.

Even if the committee wishes to discount the private operators, if it wants to say that they are not-for-profit, you still have the multiple operators owning the percentage of beds.

Mr. R. F. Johnston: Do we have information on who they are?

Ms. Fooks: Yes.

Miss Stephenson: May I ask why we would consider removing the private operators from this group? What is the different characteristic that would--

Ms. Fooks: What put us on to this was some conversations that Research Innovations had with a children's aid society which was, I believe, not very pleased that we would consider a private individual owning a home and providing care for profit. All I am trying to do is to flag for the committee that this is an area where you could get a lot of disagreement, and if we base our numbers on categories where we have private individuals as for-profit, you could have people coming to you and saying: "This is not very fair. We are not really for-profit. We are providing a service to people in need, and yes, we are being paid, but it is more of a compensation than"--

Miss Stephenson: There are all kinds of categories of services that could in fact fall into that classification, so I think we should leave them here. I do not think we should take them out.

Ms. Fooks: Okay.

Miss Stephenson: That is too fine a distinction at this point for any of us to try to make.

Ms. Fooks: It certainly drove us crazy trying to figure where we were going to put these.

Miss Stephenson: I can imagine.

Mr. R. F. Johnston: It is now under the Child and Family Services Act. This was under the Children's Institutions Act, was it not?

Miss Stephenson: Yes. That is where it began its existence.

Mr. R. F. Johnston: Historically, it was much bigger, years back. Then we brought in the children's mental health centres which started to deal with some of the clientele with mental health problems, although this group still does deal with a lot of the mental health--

Miss Stephenson: Some breakdowns, yes.

Ms. Fooks: I believe we have some information on historical data for boarding homes. You will get a better picture of that tomorrow. Table 1 is the top 10 operators. Again, we have ranked them by beds, not by number of homes. For each operator, if you go across the page--we will take number one--we have the number of homes they own and the percentage, the number of beds and the percentage within the boarding homes. Then we move to extended family homes, the number of homes they own and the percentage, the beds and the percentage.

The column that is really important here is "Total Beds." I have just collapsed the two programs because the care is the same, although the home is different. The way we ranked these was by adding up the number of boarding home beds and the number of extended family beds and doing it as a percentage. The subtotal is that the top five operators own 33.4 per cent of beds and the total is that the top 10 operators own 44 per cent of beds. That is just in under the wire for this category.

Here is an example of the problems with some of the information we got. When we asked who the for-profit operators were in this category, we were given the straight numbers and when we were asked who they were, we were given a printout of all the boarding homes and extended family homes in Ontario. Then we were given a list of who the for-profit operators were, so we had to sit down and go back and forth between the names and the printout.

We had confirmed by the ministry that the numbers one to nine are all for-profit. Number 10 is a grey area because it was not actually on the list of for-profit operators, but that could be either because it was forgotten or because it actually is not. We had a lot of cases with this ministry where things were left out or numbers were incorrect, typos and so on. It has not been confirmed whether the 10th home on this list is for-profit, but numbers one to nine definitely are.

Mr. R. F. Johnston: Not to cause too much of a problem for you, is this one of the 10? Do you have the other information or did you not manage to--

Ms. Fooks: Joan, can you please come to the microphone for a second? If I remember correctly, there was not much other activity than this. It was one or two homes and so the percentages were very small. Is that correct?

Ms. Hannant: I am not sure. I would have to see the table. I am not sure which is number 10.

Ms. Fooks: Sorry. It is the ranking of the boarding home operators by--

Miss Stephenson: Homestake House is the one.

Ms. Hannant: Homestake. We did not include it--

Ms. Fooks: We got that list. Remember, they said, "These are the for-profit operators," and they just listed the names.

Mr. R. F. Johnston: First, we should introduce our guest officially. How about that?

Ms. Fooks: Yes, this is Joan Hannant of Research Innovations who put together the report you are going to see tomorrow.

Ms. Hannant: You are referring to Homestake.

Ms. Fooks: Yes, the top 10 operators. I will restate this. The problem was that we were given a printout of all homes without any indication of the type of ownership. We were just given a list and we did not know what the type of ownership was. Then we were given a list of for-profit operators by name only and we had to go through and try to match that list with the printout.

Homestake House was not on the for-profit list. There was a lot of confusion about that list because they left out 19 operators the first time around. We were not sure whether this was a mistake or whether it was not a for-profit operator.

Ms. Hannant: But we do know it is a chain and it is sort of ispo facto that would indicate profit activity if it is operating as a chain.

Mr. R. F. Johnston: In this area, at least, it is a probability.

Ms. Hannant: A high probability.

Ms. Fooks: The only thing I am flagging is that has not been confirmed by the Ministry of Community and Social Services.

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Mr. R. F. Johnston: And we have some other statistical problems.

Ms. Fooks: Mr. Johnston, you asked whether we had information on the operators other than the top 10. Yes, we do. We can provide it if you wish.

I will not go through tables 2 and 3. They were included because when we had the ministry people here, there were a number of questions about discharged kids from these homes, how long they are staying in the home and when they leave, where they are going. That is the information here. Do I need to go over that?

Mr. R. F. Johnston: No.

Ms. Fooks: Good. Foster care is the next tab, 32-1. Again, this is one of those programs, just in case there is any doubt. There seems to be a split as to who delivers services within this program. The clientele are all wards of the children's aid society, and the majority of the homes are classified as children's aid society homes. They are not owned by the children's aid society, but they are under its supervision. The rest of them are classified as non-CAS homes owned by for-profit operators.

Here we get back to the question, do you want to consider those homes that are under the children's aid society supervision as for-profit service providers? I am not asking you to resolve that; I am leaving it with you.

The numbers you have there are 455 not for-profit, private. That excludes the children's aid society homes. It is just within the 598 non-CAS homes, which is 76 per cent of the non-CAS homes, but only 9.4 per cent of the total number of homes in the system. There are 143 for-profit homes, which is 23.9 per cent of the non-CAS homes, but only 2.9 per cent of the total.

If you consider those CAS homes as for-profit homes, other than the 455, the whole system is for-profit. If you not consider the CAS homes as for-profit, that changes your numbers. That is something the committee needs to--

Mr. Chairman: Hansard will not show that I took a coin out and flipped it for the benefit of the committee to help in its decision-making.

Mr. Henderson: It will now.

Ms. Fooks: The only real thing to note here, other than those numbers, is that the homes are not 100 per cent occupied. The children's aid society homes are only 64 per cent occupied.

Mr. R. F. Johnston: What is the number? You always know the number of homes--

Ms. Fooks: The number that are occupied?

Mr. R. F. Johnston: No, the number of children.

Miss Stephenson: How many children are there?

Ms. Fooks: We do not have those figures.

Mr. R. F. Johnston: That has always amazed me. I looked through the

estimates just the other day and there are no numbers of kids, always just the homes. The numbers of homes are declining as well.

This is a new statistic, though, the number that are actually occupied. That is new information which is usually not provided.

Miss Stephenson: There is a significant increase in the number of homes, is there not?

Mr. R. F. Johnston: Increase?

Miss Stephenson: Yes.

Mr. R. F. Johnston: It is down 2,000.

Miss Stephenson: I know, but the number of homes for foster care is up from last year or two years ago.

Mr. R. F. Johnston: Sorry. I did not bring my estimates book with me, but I was looking at it yesterday evening. In the past several years, we have declined from about 6,000 to just under 5,000. As I recall it, last year's was slightly over 5,000.

Miss Stephenson: Was it?

Mr. R. F. Johnston: I may be wrong on that.

Ms. Fooks: Behind tab 32-2 is information on the non-CAS homes. These are all homes that are not under the supervision of the children's aid society. If you go across the page, there are two distinctions there. The first three numbers are numbers of operators and the next three numbers are numbers of homes. The total number of operators is broken down into not-for-profit and for-profit and then the total number of homes is broken down into not-for-profit and for-profit.

Mr. R. F. Johnston: As I understand it, in eastern Ontario there are 18 operators for 456 homes.

Ms. Fooks: That is correct.

Miss Stephenson: And 420 which are not-for-profit.

Ms. Fooks: That is correct.

I hate to say this, but we have had some problems with the numbers of the Ministry of Community and Social Services. There were typing mistakes, decimals were in the wrong place, etc. I reconfirmed this particular set of information with them.

Miss Stephenson: Why is there such a variance in this category between the statistics for the east of the province and all the rest of Ontario? It looks very strange.

Ms. Fooks: I do not know. We would have to ask the ministries. I can only give you what they gave me.

Miss Stephenson: And this not-for-profit church?

Mr. R. F. Johnston: I think--and I do not know; I would be

guessing--there is something right now about church organizations taking the bulk of these cases in eastern Ontario, whereas in Metro, for instance, it is primarily CAS.

Miss Stephenson: It is CAS.

Ms. Fooks: Yes. I could see it.

Miss Stephenson: Is it possible to determine that?

Ms. Fooks: Yes, I can ask. They sent us this table and it was really weird. We went back and asked them to check it again and this is what we got. I can certainly ask them again.

Miss Stephenson: The figures are strange.

Mr. R. F. Johnston: Yes. The connections throughout do not make much sense to me, mostly for the east. It does not make sense to me that you would have 18 operators in total for 456 homes for this kind of a facility when you talk about a maximum of three kids in any home. That cannot be correct. It just is not possible.

Miss Stephenson: Unless some of them are not complying with the regulations.

Ms. Fooks: We can certainly go back and ask.

Mr. R. F. Johnston: We certainly need to find out.

Ms. Fooks: Moving on to child care, this is one of the areas where we imposed our own definitions on things. I will spend a little bit of time with the definitions, although I know it is boring.

One of the problems with child care is that the day nurseries information system makes it rather difficult to make comparisons between for-profit and not-for-profit centres. First, when they put all their data into the system, they do not have a not-for-profit category because a not-for-profit organization can be incorporated under the Co-operative Corporations Act or the Corporations Act.

Any organization that is incorporated under either act can choose to obtain charitable status. This means it would have to operate as a not-for-profit, but that is its choice. The noncharitable corporation category could include commercial endeavours and the not-for-profits which have not obtained charitable status. There is a bit of a problem with that.

Second, they have a category that is called "individuals for an unincorporated group." They define it as a person who acts on behalf of a group not yet incorporated. Again, it could be not-for-profit and for-profit. The Ministry of Community and Social Services puts this group in with its other for-profit categories. We have separated it out. It did not make sense that it should necessarily go into the for-profit category when they did not know whether it was not-for-profit or for-profit. So we have them as "other." If you look at the data the ministry gives you and the data we have, they will not jibe, because we have this extra category.

Third, there is a problem in terms of how they work their numbers on subsidized children. They state that it is an underestimated number, because

when a centre is opened, the number of subsidized children is not known and therefore not recorded. If you have a child care centre with a large number of subsidized children, they assume that the information system does not require that information and therefore it is not recorded.

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Miss Stephenson: If, indeed, you open a day nursery with a large number of subsidized children, the number of whom you do not know and therefore do not record, how do you find out how many are subsidized so that you can therefore assume that the system does not need the information?

Ms. Fooks: You have got me.

Miss Stephenson: This sounds like a paragraph written by a lawyer, if I may say so.

Mr. Chairman: You are out of order.

Ms. Fooks: That is their explanation as to why we should be very careful in classifying things in child care.

Mr. Chairman: We can go around again.

Ms. Fooks: Yes. However, we have put together an explanation for their operator types which I think does make things a little bit clearer. Should I go through those?

Under the not-for-profit category: There are four licensing types that the Ministry of Community and Social Services puts into this grouping. There is approved charitable, which is a corporation approved to receive direct payment for a subsidy of 80 per cent of its operating costs.

There is approved charitable corporation for handicaps. The first one is for nonhandicapped and the second one is for handicapped kids. The funding arrangements are a little bit different.

The charitable corporation is one without share capital, which has "objects of a charitable nature." That is the group we referred to before.

The next is Indian bands which form a council, and then the council provides the service as a municipality would.

I think the public sector municipal corporation is fairly clear.

The for-profit category has two licensing types. Actually, it has three licensing types but we separated out the third.

Mr. Henderson: What are "objects of a charitable nature"? Is this "objectives of a charitable nature"?

Ms. Fooks: Yes, objectives. Sorry. The two categories we have under for-profit are noncharitable corporations and private individuals. The third is this other group which, as I say, they have included in their for-profit category but we have separated out because we do not know the differentiation within that group.

If you look at the numbers, then, the numbers I have used here are as of

June 1986. There is a total of 2,127 centres. The breakdown is that the public sector owns 171 centres, which is eight per cent; the private not-for-profit owns a total of 966 centres, which is 45.4 per cent; the private for-profit owns a total of 881 centres, which is 41.5 per cent, and then we have this other, which is about five per cent of the total.

Should we go through the funding arrangements on page 2?

Mr. R. F. Johnston: Why not skip the funding because it has been an issue lately. I want to be clear about this in terms of inspections.

Ms. Fooks: Inspections, right.

Mr. R. F. Johnston: Does each consultant keep paper files on the centre each is responsible for? Does the Ministry of Community and Social Services not have a centralized information system for inspection?

Ms. Fooks: Yes.

Mr. R. F. Johnston: So even the minister does not know the results of inspections?

Ms. Fooks: Each consultant has to have the results for the centres each is responsible for.

Mr. R. F. Johnston: The policy branch of the ministry or the central planning people down here do not have that?

Miss Stephenson: For example, do the child care consultants report annually how many inspections they do? Is that in the annual report of the Ministry of Community and Social Services?

Mr. R. F. Johnston: It is not under--

Ms. Fooks: No, it is not in the annual report. I presume that the results of the child care consultants' inspections go to the program director. I would have to get that confirmed.

Miss Stephenson: If it did that, if it went to the program director then, surely it would be included in the core statistical information within the ministry.

Ms. Fooks: It is not.

Mr. Chairman: I do not purport this to be an answer, but it appears that they all fund them directly. I guess they give money to the municipalities.

Mr. R. F. Johnston: There is a range of funding mechanisms that they can go through, but the point is that there is a licensing process. As for nursing homes, there is an inspection process, but the difference is that this one does not seem to have had anything like the attention the nursing homes have had.

Ms. Fooks: We asked for any data they had on inspections, violations, follow-ups, etc. The response was that there was no centralized information system. It is simply not possible to get at the statistics in a very short time. In fact, we ran into a number of cases with the Ministry of Community and Social Services where, because so much of its stuff is done

through the regional offices, it would have taken a very long time to put together a centralized set of statistics.

Mr. R. F. Johnston: Reorganization twice removed really helped a lot in collection of information.

Miss Stephenson: I thought they were in the midst of yet another thrust to regionalization, which will probably make it even more difficult.

Ms. Fooks: Maybe I will go through the funding then. At present, the Ministry of Community and Social Services does not fund directly to the for-profit sector. However, as I am sure everybody is aware, that may be under review.

Direct capital funding under the Day Nurseries Act is available to municipalities, Indian bands and approved charitable corporations; that is, the nonprofit sector. However, the municipalities and the Indian bands may undertake purchase-of-service agreements. This is a different type of payment. There are two types of payments: direct capital funding and purchase of service on behalf of the family. They are allowed to undertake the purchase-of-service agreement with private for-profit operators, and then the Ministry of Community and Social Services subsidizes 80 per cent of that cost.

With respect to their operating costs, budgets are negotiated with the ministry. There is a detailed procedure on the kinds of information they have to give the ministry, such as monthly claim forms for the number of kids they have, etc.

Miss Stephenson: What is the accountability mechanism for the service agreements with private for-profit operators?

Ms. Fooks: The municipalities and the Indian bands simply keep statistics on how many purchase-of-service agreements they have and the number of subsidized kids within that area. Because the ministry does not fund the for-profit people directly, there is no discussion of budgetary information or operating costs.

Miss Stephenson: Okay.

Ms. Fooks: Tab 33-2 might be of some interest. When the ministries came in August, there was a question as to the salaries of day care operators. This survey is by no means very scientific, so I caution you. They did a telephone survey in August 1985 and asked people what they were making.

Mr. Chairman: They probably thought it was for the Department of National Revenue.

Ms. Fooks: For some reason, they did not include Metro, so all these areas are outside Metro. As a matter of interest, there are salary breakdowns in the municipal centres, the not-for-profit centres and the for-profit centres.

Mr. Henderson: Are these for people who are doing roughly the same thing?

Ms. Fooks: Yes. They are all child care workers in licensed child care facilities.

Mr. Henderson: These would be something like average salaries of child care workers in the respective kinds of facilities.

Ms. Fooks: Yes. Unfortunately, we do not know--

Miss Stephenson: --how many people were phoned.

Ms. Fooks: Yes.

Miss Stephenson: Or where they were within the system.

Ms. Fooks: Yes.

Miss Stephenson: Are these ranges within the municipal and nonprofit centres, or are they in fact salaries?

Ms. Fooks: They are ranges.

Mr. R. F. Johnston: We would not even necessarily know the qualifications of the people we are talking about.

Ms. Fooks: As I say, it is not a very scientific survey.

Mr. Henderson: They are not even averages.

Miss Stephenson: No. They are ranges.

Mr. Henderson: You could have everybody at one end and one person at the other, and you would get that range.

Ms. Fooks: I recognize there are many problems with this. I just put it in to give you a very basic indication.

Mr. Chairman: You wonder why anybody would work in the commercial sector.

Mr. D. S. Cooke: The thing with the commercial sector is that it has fewer numbers of qualified staff; so even though the \$87.50 is extremely low, even if they are unqualified--that may be a person who has not gone to college.

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Mr. Henderson: One hopes they at least corrected for part-time and full-time. Do we even know that?

Ms. Fooks: No. All we know about the survey is at the bottom of this page. That is all they were able to tell us.

Mr. Henderson: The ones under "commercial" could all be working a period of time?

Ms. Fooks: It is possible.

Miss Stephenson: I think the best thing to do with this is dispose of it.

Ms. Fooks: You are right. There is a lot of information in here that we can probably dispose of.

Mr. Chairman: Is that a motion?

Miss Stephenson: I do not see that this sheet is ever going to do us any good.

Mr. D. R. Cooke: It could be very misleading for a report we actually published.

Miss Stephenson: That is right.

Mr. Henderson: The trouble with these bad statistics is that even though you qualify them and say they are--

Miss Stephenson: Somebody picks them up.

Mr. Henderson: Somebody just picks them up and says, "These were the figures."

Miss Stephenson: Some radio voice will.

Mr. Chairman: Are we eliminating table 1 then?

Miss Stephenson: I think it would be wise to, because it really is not scientifically valid and there is no way we can find it useful.

Ms. Fooks: I know. I simply put that in--

Miss Stephenson: I move we eliminate it. Unless there is a better statistical survey, I think we should leave this one out.

Mr. Chairman: Table 1 is eliminated.

Ms. Fooks: Again, it is an example of some of the problems we have had.

Mr. Chairman: Collect them from the briefs that are still there for the members who have left.

Miss Stephenson: Research is taking them all back tonight, so they can be taken out then.

Ms. Fooks: Table 2 deals with the number of subsidized children in the system. It is broken down by exactly the same kinds of licence information.

Table 3 deals with enrolment and capacity. Again, these are exactly the same breakdowns of operator type. The enrolment and capacity differ because the enrolment represents full-time spaces used for two children. The payment goes for one full space, and they actually have one kid in the morning and one kid in the afternoon using that space, so the enrolment numbers are much higher than the actual capacity numbers. The capacity numbers are licensed number of spaces. The enrolment numbers are the actual number of children in the licensed day nursery centres, broken down often by two children in one space.

Miss Stephenson: Do these statistics include those programs, which have been established in a considerable number of schools, in which the service is provided before school, during lunch hour and after school?

Ms. Fooks: I doubt it. These are for licenced day nursery centres.

Miss Stephenson: But these have been granted some kind of licence. I do not know exactly what the quality of that is.

Ms. Fooks: I am not sure. If they have been granted a licence under the Day Nurseries Act, then they will be included in these groupings, but if they do not have that kind of a licence, they will not. We can check and see.

Miss Stephenson: There are a considerable number of them, as a matter of fact.

Mr. Chairman: If I am thinking of the same ones you are thinking of, they normally operate through the budget of the regional municipality or the county.

Miss Stephenson: No, not at all. As a matter of fact, they were approved by the Ministry of Community and Social Services, specifically by the regional manager of the Ministry of Community and Social Services, with recommendations to the minister. Then the minister approved it and provided capital funding to establish it in the first place.

Mr. Chairman: I thought they were funded by the region.

Miss Stephenson: There may be some funded by the region but there are some not funded by the region as well. They are co-operative, not for profit and established within empty classrooms within schools.

Ms. Fooks: We were given some information on parent co-operatives but I do not know if it was the same situation you are talking about.

Miss Stephenson: I am not sure one could classify all of these as parent co-operatives because there are a number of those as well.

Ms. Fooks: We can certainly go back and ask them. We are on the last program. For the member who just came in, it is tab 34-1. We have not done them all.

Miss Stephenson: We have leaped, jumped and skipped.

Ms. Fooks: The family home program is for the developmentally handicapped wishing to live in the community. There are two components to this. There are the actual homes themselves. There are 99 of these homes; these are where the clients actually live, but the homes are operated by family home agencies. Again, you have the question about whether these homes are going to be considered in the for-profit category. The family home agencies are not. They are all not for profit. They are either voluntary, charitable or a municipal agency and they supervise the homes. There are 99 homes. Sixteen home agencies are operating 99 homes.

We have a total of 136 clients in the program. The fee that is paid is \$18 per day per client. So if you are going to classify those homes as for-profit activity, then the program is completely for profit.

Mr. D. S. Cooke: This is not the same as foster care.

Ms. Fooks: Yes; it is a different clientele. Instead of having wards of a children aid's society, they are developmentally handicapped adults. But it would be a similar type of residential care.

Mr. Chairman: There is one in each household?

Miss Stephenson: Up to three.

Ms. Fooks: Up to three is the maximum. At the moment, there are a total of 136 clients. We do not have a printout of the family homes in terms of addresses. All we have is what we have been told, that there are 136 people in this program.

Mr. Chairman: Is the reason for the difference between the \$18 and the \$20 that we saw in another program because of the Gains contribution?

Ms. Fooks: I could not tell you. I am not in a position to answer questions as to why the ministries have decided certain things. I would guess that would be a reason because the clients do pay for their own room and board through the Gains allowance.

The last table is a listing of the locations of the actual family homes.

Miss Stephenson: These are the family home operators or agencies--

Ms. Fooks: Agencies; that is right.

Miss Stephenson: The sites of the homes are not necessarily within the urban areas. They used to be. A lot of them are rural or at least semi-rural.

Ms. Fooks: There is one family home agency in Toronto. How many homes that particular agency oversees, we do not know.

That completes the top category for the Ministry of Community and Social Services. We have now done, for the Ministry of Health and Ministry of Community and Social Services, those programs that are greater than 45 per cent.

Miss Stephenson: Using the assumptions that we have established?

Ms. Fooks: Yes. I am in your hands as to where you would like to go from here.

Mr. Henderson: Would you like to reorganize the system and implement it?

Miss Stephenson: First, you were going to put this into a binder for us so we can have an opportunity to peruse the entirety of the information.

Ms. Fooks: Yes. That will be done tomorrow. If you like, we can move down through other categories or if you want, you can look through the index to see if there are particular programs you are interested in. Category 4 are programs that, for want of a better word, we have called worth watching. When you look at the trends over time, there has been some increase in the for-profit activity. I do not know if you would like to go through those.

Mr. R. F. Johnston: If they are worth watching, let us watch them.

Ms. Fooks: The material for that particular category will probably be explained in more depth tomorrow, because Research Innovations is going to the trend stuff. So I am at your disposal on what you would like to do.

Mr. D. S. Cooke: We are going to have a vote soon.

Mr. R. F. Johnston: If that is the case, I suggest we have two things. We have received a lot of information, and there is always the danger of information overload at an earlier point with members of the committee.

Miss Stephenson: It is best to know your cells are functioning.

Mr. R. F. Johnston: We do have the report of Research Innovations that we should be reading over and we have the vote upstairs. Why do we not end the day and reconvene tomorrow?

Mr. Chairman: Is there any dispute with that?

Interjections.

Mr. Chairman: That is true.

Interjections.

Mr. Henderson: What we are saying is that we have to have a little time to pick ourselves up off the floor.

Ms. Fooks: I apologize for that. I know it is really tough to get through.

Mr. Henderson: Not at all. I think you have done a swell job. I was going to say that whatever the deficits of the information may be, it has nothing to do with you. Obviously, you and whoever you work with did an excellent job of pulling all this together.

Miss Stephenson: And organizing it.

Mr. R. F. Johnston: That is true.

Mr. Chairman: If members will leave their folders where they are, they will be suitably accommodated with a hardbound looseleaf binder.

Ms. Fooks: I promise. I will bring them back tomorrow in a binder.

Mr. Henderson: Does the committee meet tomorrow morning or tomorrow afternoon?

Mr. Chairman: The committee meets tomorrow after routine proceedings. We will be dealing with a presentation by Research Innovations--the information you have before you now.

The committee adjourned at 5:02 p.m.

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SELECT COMMITTEE ON HEALTH

COMMERCIALIZATION OF HUMAN SERVICES

THURSDAY, JANUARY 22, 1987



SELECT COMMITTEE ON HEALTH

CHAIRMAN: Callahan, R. V. (Brampton L)
Andrewes, P. W. (Lincoln PC)
Baetz, R. C. (Ottawa West PC)
Caplan, E. (Oriole L)
Cooke, D. S. (Windsor-Riverside NDP)
Hart, C. E. (York East L)
Henderson, D. J. (Humber L)
Johnston, R. F. (Scarborough West NDP)
Reycraft, D. R. (Middlesex L)
Stephenson, B. M. (York Mills PC)
Turner, J. M. (Peterborough PC)

Substitution:

Sheppard, H. N. (Northumberland PC) for Mr. Turner

Also taking part:

Ferraro, R. E. (Wellington South L)

Clerk: Deller, D.

Staff:

Labelle, R., Lecturer, Department of Clinical Epidemiology and Biostatistics,
McMaster University

Stoddart, Dr. G. L., Associate Professor, Department of Clinical Epidemiology
and Biostatistics, and Associate Member, Department of Economics, McMaster
University

Witnesses:

From Research Innovations:

Hannant, J., Research Director

Yalnizyan, A.

Poirier, G.

LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON HEALTH

Thursday, January 22, 1987

The committee met at 2:40 p.m. in committee room 2.

COMMERCIALIZATION OF HUMAN SERVICES
(continued)

Mr. Chairman: I recognize a quorum. I am not certain whether the House is still in routine proceedings. I am going to assume it is not and we are going to begin.

Mr. R. F. Johnston: It must have been. We have been here for ages.

Mr. Andrewes: A real stickler for procedures.

Mr. Chairman: If I am going to do something, I want to have the support of everybody on the committee in doing it. I gather, with nobody objecting to it, you are all in the boat with me.

Mr. Andrewes: You have our undying support.

Mr. Chairman: As I understand it, we are going to go through your report today, so perhaps you would like to proceed.

Ms. Hannant: I am going to forego some of the--you have the report already.

Mr. Chairman: I am sorry. Perhaps you will identify yourselves for Hansard. We know who you are but they do not.

RESEARCH INNOVATIONS

Ms. Hannant: I am Joan Hannant of Research Innovations. This is my associate Guy Poirier and my other associate Armine Yalnizyan.

Our presentation today will attempt to make some sense of the voluminous document you received yesterday. Before I begin, I should point out that for the purposes of our discussion we will focus on only those programs where for-profit activity either has been high or displays dynamic or noteworthy trends. Within this framework, we will be referring to only those programs for which we were able to obtain historical data.

Yesterday, Ms. Fooks very nicely reviewed those data where we predominantly did not have trends and those data were the top two categories we looked at. Our presentation will focus on the overall trends of for-profit activity. We have limited time. I would prefer to field questions after I present it.

Mr. Chairman: We have agreed to that.

Ms. Hannant: Was that agreed to yesterday? Then I agree to it today.

Mr. R. F. Johnston: Very disciplined.

Ms. Hannant: Our most major finding suggests that the experience of for-profit activity differs markedly between the Ministry of Health and the Ministry of Community and Social services. We have five primary indicators that suggest this.

First, in terms of the extent of for-profit activity, there are marked differences between Health and Community and Social Services. Second, there are also differences for the growth of for-profit activity in the two ministries. Third, we found significant differences between the nature of for-profit operations in the two ministries. Fourth, we also found significant differences in the level of corporate concentration between the two ministries. Fifth, and last, we found differences between the regulatory mechanisms in the two ministries.

Our presentation today will focus on these five major trends and indicators. The first one I want to deal with then is the extent of for-profit activity in the two ministries. You will have received two handouts. This is not the summary of findings; it is the one that starts off with a breakdown of the levels of for-profit. On page 2 of that handout--

Mr. Chairman: Does everybody have a copy? I understand it is this one. Is that correct?

Ms. Hannant: I cannot see. Yes, that is it.

Mr. Chairman: I cannot see it even there.

Ms. Hannant: I will give you the benefit of highlighting or reading it for you. On page 2, in terms of the Ministry of Health, you will note that eight programs out of the 16 we examined have experienced for-profit activities. Much of that was increasing. In other words, if you look at the third column, "Share of Market Served by For-Profit Sector," we have indicated the level of for-profit activity, normally in terms of capacity, and that is where it stands right now as of December 1986. Then in the far right column, we make a comment about "Trends in Market Share Over Time." Where we say "unknown," it means we did not get historical data, so we could not determine whether it was increasing or decreasing over time.

The point of this sheet is simply that, in comparison to Community and Social Services, much of the for-profit activity is increasing.

On page 3, we look at what is happening vis-à-vis the Ministry of Community and Social Services. We see here that 13 out of the 15 programs of Community and Social Services that we examined experienced some level of for-profit activity. That level ranges from one per cent to 100 per cent. You will notice in the far column there are a lot of "unknowns." For us, it was very difficult to make any summary vis-à-vis Community and Social Services, because so much of the historical data were incomplete.

For what we do know, for-profit activity in this ministry was constant over the period. It was not increasing over the period in the same way that it was for Health. However, we want to emphasize that what we do not know is more than what we do know for this ministry. In our view, much more work needs to be done before we can get a good picture of what has been happening to the

Ministry of Community and Social Services in the period we have been looking at.

The second indicator I want to look at is the trends in for-profit activity. I will first look at the Ministry of Health. Of all the programs that show substantial expansion in commercial sector activity, laboratory--

Mr. Chairman: Are you reading from a particular page, so the committee members can follow?

Ms. Hannant: No. You can look at the executive summary. It might be helpful. Some of what I am about to say will come from the text. Everything I have to say is in the text in some way, shape or form.

Mr. Chairman: Rather than all of us searching around; I thought you were reading from something. Go ahead.

Ms. Hannant: I am reading from my notes, so you will have to dig around. We are going to have some graphs we will show. There is one. That is excellent timing.

With regard to Health then, of all the programs that show substantial expansion in commercial sector activity, laboratory services stand out as noteworthy, primarily because these services were already quite commercialized at the beginning of the period under review.

The first graph on the screen denotes a decrease in the number of private lab facilities--that is, commercial lab facilities--and a concurrent increase in the number of tests. Despite the growth in revenues to private sector labs, the actual number of private labs has decreased by one third between 1976 and 1986, from a total of 265 labs to 175 commercial laboratories. The volume of services provided by the for-profit sector has doubled over the same period, indicating increased corporate concentration. We will refer back to the issue of corporate concentration later in our presentation.

Yes?

Miss Stephenson: I am sorry. We are not supposed to ask questions.

Mr. Chairman: No. I have been itching to ask one and it may be the same one you want to ask.

Mr. R. F. Johnston: I wonder if it is.

Miss Stephenson: I doubt it.

Mr. R. F. Johnston: We will never find out.

Mr. Chairman: Go ahead. We have agreed to withhold the questions, so Dr. Stephenson is going to do that.

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Ms. Hannant: With regard to share of payments, over a 10-year period dollar payments to laboratories in Ontario have more than tripled from \$156 million in 1974-75 to \$539 million by 1985. However, different sectors of the market for laboratory services grew at different rates. Public health

laboratories make up the smallest share of the market. Even though payments to this sector doubled between 1974-75 and 1984-85, the general expansion of the market occurred at a much higher rate, resulting in a loss of from four per cent to 2.6 per cent of this sector's share of revenue in this market.

Miss Stephenson: I wonder why.

Ms. Hannant: Should I proceed?

Miss Stephenson: Oh, yes. Go ahead.

Ms. Hannant: With regard to hospital labs, they too have grown quite rapidly, but they have not kept up with this general expansion of the market. Dollar payments to hospital labs have tripled since 1974, but nevertheless their proportionate share of the market has been steadily shrinking. While this category accounts for the largest share of the market, hospital labs now comprise only 59 per cent of dollar payments to labs.

Commercial laboratories, on the other hand, have surpassed the average total group in the market, multiplying its revenues four and a half times. It has therefore picked up the share of the market lost by hospitals and public labs, almost a 10 per cent share during the last 11 years. This category now comprises almost 40 per cent of the dollar payments in lab services. Its share of the market seems to be increasing on average by about one per cent a year.

Miss Stephenson: I guess my only question is, do you know why? You have no idea why. You simply reported the factual statistical information and nothing more.

Ms. Hannant: That is right. Our mandate asked us to compile an inventory. We could talk later about why.

Miss Stephenson: We know why.

Ms. Hannant: Yes.

Miss Stephenson: Right. It has nothing to do with whether they are commercial or otherwise.

Ms. Hannant: The second area we want to look at is nursing homes. It is worth emphasizing nursing homes.

Mr. Chairman: Excuse me for a second. For the benefit of those who have not already twigged to it, the graphs that are going up on the board are in the handout we originally started with.

Ms. Hannant: You have two handouts there; one of them is the summary of our findings.

Mr. Chairman: Yes. It is the other one that the graphs are in.

Ms. Hannant: Yes. The second one gives you a snapshot picture of the level of for-profit activity in all the services we reviewed. It also represents the graphs. The only problem with that handout is it is not necessarily in the order that you are going to see the graphs on the screen, so there may be more shuffling of paper than you want. You are probably best to follow the screen. I will proceed with nursing homes.

It is worth emphasizing that the for-profit sector of the market dominates the provision of nursing home services at this time. Of all nursing homes, 91 per cent are run by private for-profit operations. We do not know, however, how this level of commercial activity has changed over time.

Between 1976 and 1986, we do know that the number of facilities has steadily decreased from 387 to 332. While the number of facilities has declined, the number of beds has consistently increased throughout the period, growing from approximately 26,000 beds in 1976 to 30,000 beds in 1986. This has resulted in a substantial growth in the average size of facility during the period under review. As our data show, there is no suggestion that this trend is slowing down or reversing. Nursing home facilities, it should be noted, are more than one third larger in 1986 than they were in 1976. In today's market for this service, the average facility operates 90 beds.

A second, and in our view noteworthy finding with regard to nursing homes is the per diem rate structure. The differentials between government contributions to private room and standard room rates have decreased over time, as can be seen from the graph on the screen, "Nursing Home Per Diems."

The gap between the cost of private room and standard room accommodation narrowed substantially over the period. Today, the government's share of standard room rates is 58 per cent, down from 65 per cent in 1976, while government contributions to private room rates have increased steadily over the period. Therefore, residents in standard room facilities pay more out of pocket today than they did 10 years ago and residents in private room accommodations pay proportionately less.

Turning now to trends in homemaking services, we have categorized this as an area where, you will note, there is relatively little for-profit activity, but in our view the growth in the period we were examining was so significant that it warrants closer examination.

The total number of home-nursing visits increased two and a half times between 1978 and 1986. Homemaking services increased three times over the same period. Although private not-for-profit operations dominate the provision of these services, the private for-profit sector demonstrated a dramatic expansion over the period in both home-nursing and homemaking services.

Services provided by private for-profit operators have shown considerably more rapid growth than by nonprivate operators. Because for-profit agencies are growing more rapidly than nonprofit agencies, they are consuming a greater share of the home-nursing-visits market. While this proportion is still relatively small, it is expanding at a dramatic rate.

A somewhat similar pattern emerges in the case of homemaking services. Here, however, the for-profit agencies are already more established within the market than they were for nursing visits at the beginning of the period. Again, services provided by the for-profit sector expanded much more rapidly than those by not-for-profit agencies. While hours of for-profit service quadrupled between 1978 and 1985, private not-for-profit services only tripled.

Just as these different rates of change produced a different market structure in home nursing, a similar observation can be made vis-à-vis the changing structure of the homemaking market. In 1978-79, for-profit agencies only provided 18 per cent of the hours of homemaking services. By 1984-85, this had increased to 24 per cent of the market. These trends, in our view,

appear to mirror the American experience of the recent past, albeit to a much lesser degree.

The push towards deinstitutionalization in the American health care field has created a service vacuum that increasingly is being filled by for-profit operations. In 1978, for-profits occupied in the US market five per cent of home care services. By 1984, their share of the total market had increased to 30 per cent.

The second area I want to discuss, although the levels of commercial activity are relatively low, in our view warrants some closer examination has to do with the purchasing of services inside hospitals. Slightly different in nature than the other programs discussed in the Ministry of Health, this section refers to the supply of different types of support services required in a hospital setting that may be provided in-house or contracted to the private for-profit sector. Overall, we found there is a consistent trend of growth throughout the country with respect to the share of hospital services being contracted out to outside agencies.

There is no indication that the rate of expansion of purchased services is slowing down. Canada-wide, other jurisdictions have been increasing the share of purchased services in total cost at a greater rate, it should be noted, than in Ontario over the period 1976 to 1984, but the differential in the rate of growth is not great.

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While some specific purchased services remained a stable part of departmental activity during the period under review, two functions show a steadily increasing reliance on the provision of service by contracted for-profit operators. The greatest growth is seen in the purchase of maintenance and repair services. In 1984-85, about 15 per cent of total costs for maintenance and repairs in hospitals was allotted to contracts to the for-profit sector. This is up 12 per cent from 1976.

Purchased services represented about 51 per cent of total departmental costs in laundry services in 1984-85, for a total dollar value of \$45.6 million. It is interesting to note that while costs have increased at a rate just above inflation throughout the period, the actual volume of service provided by contract to for-profit operators has increased by 31 per cent, compared to an overall increase of 13.6 per cent in the volume of laundry utilized by hospitals. This accounts for the steady increase of purchased services as a share of all laundry and linen processed by hospitals over the period.

Another interesting trend is noted in the purchase from the for-profit sector of food services. Although the real--that is, the deflated--costs of the total amount of purchased services increased by 14 per cent between 1976 and 1985, the total number of meals actually served by private contractors declined by five per cent. In current dollars, however, hospitals paid \$19.7 million for purchased food services in 1984. This is up from \$8.9 million in 1976.

A second major trend we wanted to note with respect to hospitals is the activity for uninsured residents. In addition to the developments noted for purchased services, a second major trend, in our view, warrants closer examination. A different type of private sector activity is beginning to creep into the provision of hospital services. The payments made to hospitals by

uninsured residents leapt from \$4 million in 1976 to \$44 million in the 1984-85 fiscal year.

Although such payments represent a very small share of the total hospital operating revenues, this trend is steadily growing and shows no signs of abating in the near future. This is significant, in our view, in that it appears to mirror recent trends experienced in the United States, where provision of institutional health services has reverted in some instances to a system of individual, not social, responsibility.

Miss Stephenson: Can I ask a question for verification?

Ms. Hannant: Yes.

Miss Stephenson: "Uninsured residents" in fact applies to services provided by the hospital that are not insured.

Ms. Hannant: No. That is another category that you are referring to. The business-oriented new development program has affected that. These are residents who have no Ontario health insurance plan coverage.

Mr. Chairman: Or people from outside of Ontario.

Ms. Hannant: No, residents of the province.

Miss Stephenson: Residents of Ontario. There is an increase in the number of those who have no insurance?

Ms. Hannant: There is a number in terms of hospital revenues. There is an increase in the amount of revenue coming to hospitals for that class of patient.

Ms. Yalnizyan: Excuse me. Can I just clarify a few things?

Miss Stephenson: Yes.

Ms. Yalnizyan: This growth that we note from \$4 million to \$44 million is what is coming out of pocket from uninsured residents. In other words, they are not paying OHIP premiums. They are ending up in hospital and they have to pay out of pocket. That increased from \$4 million to \$44 million in the period we looked at.

Miss Stephenson: What is the increase of the number of uninsured under OHIP? Do you have any idea?

Ms. Yalnizyan: We do not have any idea.

Miss Stephenson: Does OHIP? You have not explored that?

Ms. Yalnizyan: It is not possible to extract that kind of information from the data we received.

Miss Stephenson: Not from the data you received, but OHIP has some information about the numbers of residents in the province who in fact are not insured. They do not have firm figures, but they have some indication.

Ms. Yalnizyan: I am sure it would be an estimator, however, because you would not be able to keep tabs on the kind of turnover you are getting in

and out of the province. Death and all sorts of parameters have to enter into that.

Miss Stephenson: Yes, but they do know the trends and they did have an annual estimate--

Mr. R. F. Johnston: A percentage.

Miss Stephenson: A percentage of those who were covered. We do not have that information.

Ms. Hannant: No, not in this report.

Ms. Yalnizyan: But certainly these data would signify that this is something that should be looked at.

Dr. Stoddart: A point of clarification: Maybe something should be checked. Maybe members of the committee have the same understanding that I did of the Canada Health Act. I thought the significance of it was that payment of premiums was not necessary any more for entitlement to service in this country, and therefore, the concept of an uninsured person seems to me to be, in a sense, a concept that has passed.

Mr. R. F. Johnston: We can all start to withhold our premiums, then.

Interjection: An NDP policy at last, through the back door.

Dr. Stoddart: That is what the act says, anyway.

Miss Stephenson: I think there is a degree of ambiguity about it, as a matter of fact, which probably needs to be clarified. It does not say that as clearly as you might like it to say it.

Dr. Stoddart: For the record, I think we should say that the concept of an uninsured person has not been defined as it pertains to 1987. How is that?

Miss Stephenson: Right. That is better.

Mr. Chairman: Can I get that clarified? Does that mean that if someone does not have OHIP and he receives services of whatever type under the health care system, it is covered by the government?

Miss Stephenson: In most instances for the past 10 years, it has been. That is why I am astonished at the level of increase of individual payment for hospital services from Ontario residents who are declared to be uninsured. In almost all circumstances, where there was any kind of problem with an Ontario resident, OHIP simply reimbursed the hospital.

Mr. Chairman: That is what I wanted clarified. When you say it increased to \$44 million, are you saying that the government picked it up or that people actually paid out of their pocket?

Miss Stephenson: Out of pocket.

Ms. Yalnizyan: It is out-of-pocket payment, from what we can understand to be the definitions of the different categories of the data that were supplied.

Ms. Hannant: It may not in fact be out of someone's pocket, but that is a share of revenue.

Ms. Yalnizyan: In the actual section, when you get into the Ministry of Health program and look at the tables we provide, the data are divided by shares of operating revenue to hospitals, both in current and in constant dollars. That data breakdown is where the hospital is getting its global operating revenue budget from, and of those different categories, one category is called uninsured resident. From what we were able to pull out of that information and definite clarifications on definitions, it seemed to us that that is what it was saying: that the uninsured resident is paying \$44 million today out of pocket for services. Maybe that is a misunderstanding on our part.

Mr. Chairman: Surely that has to be a misunderstanding, because if the person cannot afford, or for whatever reason is not paying his OHIP premiums, I doubt very much that it could be that much money being paid out of the pockets of Ontario residents who choose not to have the insurance. It does not make any sense. It sounds as if what is happening is that the government is doing exactly what Miss Stephenson says it has been for 10 years, picking up the cost. That is why they called them--

Miss Stephenson: When it is necessary.

Ms. Hannant: When we are looking at Ontario hospital statistics and we are looking at how that is classified as operating revenue, as far as the hospital is reporting that revenue, that is how they report that class of revenue.

The only point here is that, for whatever reason, that is the one area we looked at where there is significant growth, significant activity, over the period. Everything else, for all classes of sources of revenue, has remained relatively stable throughout the period.

Ms. Labelle: We should probably check on this, because my understanding is that "uninsured residents" covers not only uninsured residents but also portions of services that are uninsured. OHIP has a lot of partially insured services.

Miss Stephenson: That is what I asked first, whether it was uninsured services.

Ms. Hannant: That is a separate category.

Ms. Labelle: I am looking at H6a from your text, on page 44. Where would that come into their revenue?

Ms. Yalnizyan: The IRNRN category, which is in table H6, is the category you are referring to right now. That means--if I can remember what it means--

Ms. Hannant: "Insured residents not the responsibility of the ministry."

Ms. Labelle: That is what you are referring to.

Ms. Yalnizyan: That is different from non-patient-specific services such as the business-oriented new development program, because BOND is not--

Ms. Hannant: That category and the growth in there would reflect the implementation of the BOND program.

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Ms. Labelle: Yes, but you see, there are patient services that are provided that are not eligible under the BOND program--

Ms. Hannant: Precisely.

Ms. Labelle: --like in vitro fertilization, where for a while the government paid only a portion of that. Where would the portion paid by the patient for the uninsured part--

Ms. Hannant: In that category.

Miss Stephenson: In the \$44 million.

Ms. Labelle: That is my understanding of that category, and the IR, whatever it is, is just the BOND, nonpatient-related services revenue.

Ms. Hannant: Not necessarily. These are the residents who are uninsured, not uninsured services. The category "insured residents not the responsibility" means the services are not the responsibility of the ministry. The growth in that activity could be explained by the implementation of the BOND program, which does not mean that the example you use somehow negates that. In other words, the BOND activity is reflected in that category, as are specialized services that are not insured.

We are talking about residents who have, for whatever reason, no insurance, and whoever is picking it up--most of that, I am sure, is not coming out of pocket--the point is that it is sustaining growth in that category, and in our view, certainly, we would want to know why.

Miss Stephenson: For about 15 years there has been a very small but significant percentage of citizens in the province who choose not to participate in OHIP, and the only rationale that I can see is that the costs within hospital have increased so dramatically that this small but significant group is incurring a hell of a lot more cost now than it was 10 years ago when the figures began to be kept.

I am not sure it is of the order of 11 times what it was then, but it is getting pretty close to it in spots. Some of the costs of laboratory techniques, which may be sampled within the hospital but sent outside to the private laboratory where the test is done, because the hospitals cannot do it, are included in that as well.

Ms. Hannant: Yes. The increase we refer to is in real dollars; in constant dollars, it is about six per cent over that period.

Miss Stephenson: That is more rational, then.

Mr. Sheppard: Mr. Chairman, if I may ask, what do we citizens pay in OHIP fees? Have you got that figure at the end of your fingers?

Miss Stephenson: In terms of the total cost? No, that is not part of their investigation at the moment. It is something in the order of 19 per cent of the total cost.

Mr. Chairman: Can I interrupt for a second? We are going to give Hansard an Excedrin headache if we have more than one voice at a time.

Miss Stephenson: A double Excedrin headache.

Mr. Chairman: Yes. We should just keep that in mind.

Mr. R. F. Johnston: I know in Orillia they found that something else worked.

Miss Stephenson: And Kamloops and Lunenburg.

Mr. Chairman: Tylenol, I think it is; Tylenol 4.

Ms. Hannant: In any event, I will go on now to the Ministry of Community and Social Services and look at the trends in that ministry.

We want to point out that we have time series data only for three programs. None of these programs, we also want to point out, experienced relative expansion of the for-profit sector market, so while the examples we have just referred to in the Ministry of Health reflect some kind of expansion in terms of for-profit activity and we can note that in the Ministry of Health overall, in the Ministry of Community and Social Services we do not find the same kind of pattern.

Nevertheless, I am going to run through some of the programs very quickly where we have historical data.

For-profit activity has increased in absolute terms, however, since 1980 in licensed day nurseries, but in relative terms the share of for-profit activity in the total market has remained relatively stable over the period. By December 1986, the market in Ontario for licensed day nurseries was composed of 2,226 centres, which could handle a total capacity of 82,280 spaces. The largest share of this market, with respect to total licensed capacity, is controlled by for-profit operations. This sector provides 45 per cent of all spaces in Ontario's licensed day nurseries.

Private not-for-profit centres, however, have shown the greatest growth overall. Since 1980, 376 nonprofit centres have been added to the market. This growth has been especially oriented towards part-time enrolment. Today, 45 per cent of all part-timers are enrolled in nonprofit centres, making this the most dominant ownership type for the provision of part-time day care services. Ministry expenditures on regular day care centres have increased from \$25 million in 1976 to an estimated \$131 million in 1986. Total expenditures on day care have increased at almost twice the rate of total ministry expenditures over the period under review.

Although the level of for-profit activity remained at 100 per cent throughout the period, changes were noted with respect to children's boarding homes. Overall, there has been a decline in this service. From 1975 to 1980, the number of private children's boarding homes doubled from 134 to 269. By 1986, however, the total number of homes declined from 269 to 189. Similarly, after an initial increase between 1975 and 1980, a significant decline is noted with respect to capacity.

In 1986, corporate concentration among extended family units, which we will talk about in more detail later in our presentation, was much higher than it was among private boarding homes, where the top four chains provide only 15

per cent of total capacity. Of the 129 extended family units operating in 1986, 123, or 95 per cent, were owned by chains. Although the top four firms control over 80 per cent of the total capacity provided by this market, the top-ranked corporation alone, Ausable Springs, controls over 50 per cent of both capacity and number of facilities for this market.

There are similar trends in foster homes. What you have before you shows declining trends in volume of service and occupancy rate. This is denoted by the increasing difference in the height of bars for each year.

Since 1976, the number of children's-aid-approved foster homes has decreased by 11.2 per cent. This rate of decline in the number of approved children's aid society homes was surpassed by the decrease in the number of occupied homes, 20.6 per cent.

Interjection.

Mr. Chairman: Mr. Andrewes, were you speaking?

Mr. Andrewes: I think that is what it is called. Is that two categories? I guess that is my question.

Ms. Hannant: Yes. The description describes what it is. An approved home is a facility that has been approved, and an occupied home is an approved home that is occupied. The point we want to make of that, though, is that in 1986, 64 per cent of all approved children's aid foster homes were occupied, compared to 71 per cent in 1976.

Two other programs administered under the Ministry of Community and Social Services, in our view, merit closer examination, even though the level of commercialization is not currently great. First, with respect to homemakers and home nursing services, unfortunately the ministry was not able to locate any historical data except with respect to current status. The reason, though, that we want to include the program, homemakers and home nursing services, under our category of those worth watching or under our category that could also be described as one where we see dynamic or noteworthy growth or developments in the period under review, is simply because of the resemblance or similarity between this program and the Ontario home care program that is administered under Health.

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We can only speculate at this point there is a high probability that the provision of these services is undergoing similar developments that were noted with respect to the Ontario home care program.

Miss Stephenson: Some may be totally integrated.

Ms. Hannant: I can say a little bit more about the homes for the aged with respect to satellite homes. Again, this is an area that we simply wanted to flag. Again, unfortunately, as it turns out with the Ministry of Community and Social Services, we do not have historical data here; in our view, it would be interesting to try to locate such data. We tried.

Although there are no private for-profit homes for the aged, there is a potentially significant form of for-profit activity which affects the clientele specific to this program; that is to say, satellite beds. Of the 52 institutions which offer satellite beds, 45 are for-profit operations. These

provide 72 per cent of the 799 such beds that were available to the elderly awaiting entry to homes for the aged in 1986. Unfortunately, because we do not have historical data, we cannot tell whether this has increased or decreased over time. However, because the needs of an increasingly ageing population are not being met by the system as it presently exists--hence the use of satellite beds in the first place--the satellite bed option suggests that this form of for-profit activity should, at the very least, be monitored for change.

That is my review of the trends in growth patterns with respect to for-profit activity in the two ministries. I want to shift gears a little bit and say something about the nature of for-profit activity in the two ministries before I look at corporate concentration.

In programs administered by the Ministry of Community and Social Services, the for-profit activity seems to be dominated by sole proprietors, individuals and limited partnerships. We discussed that briefly yesterday with respect to foster care providers.

Those type of operators seem to dominate the programs offered under the Ministry of Community and Social Services; that is in foster care, day nurseries, family home programs, etc. For-profit activity in the Ministry of Health, however, appears to be dominated by corporate activity. We can see this with respect to nursing homes, labs, home care purchased services, etc. These are very rough indicators of the types of different operators who dominate the market in the two different ministries.

The next indicator I want to look at is corporate concentration. We have data describing corporate concentration for four Ministry of Health programs. Out of these, an analysis of changes in the degree of corporate concentration was possible only for laboratories.

Before looking at them, I want to say something very brief about nursing homes. Corporate concentration in the nursing home industry is very low with respect to the number of facilities in the market. It appears to be somewhat higher with respect to capacity, but there are certain anomalies in this market, the most noteworthy being Extendicare and to a lesser extent Versa-Care and Diversicare, which altogether control a significant portion of this market so the top three control a reasonably significant portion of the capacity in nursing homes.

With respect to laboratories, this is the only service for which we have time to series data with respect to corporate concentration. Our findings indicate there is an increasing degree of concentration in commercial laboratories.

Corporate concentration has not only been consistently high in this market, it has been growing steadily in the last eight years. Together, the top 10 ranking chains have increased their market share from 62 per cent to 70 per cent of the total volume of lab services performed by the commercial sector. By 1985, the top five chains held 52 per cent of this market.

The pattern of steady increase in market share by the top commercial firms is not likely to change. In the past two years, only one new corporation received approval to run labs in Ontario. However, this corporation merely purchased, we should note, an existing lab chain. As pointed out yesterday, no new licences have been issued by the ministry for a considerable time.

With respect to corporate concentration in the purchased service market in hospitals, the following graphs show that a small number of private contractors dominate the provision of services supplied by the for-profit sector to hospital services in virtually every type of service. The provision of purchased services from the private sector to hospitals in this province displays a high degree of corporate concentration, regardless of the type of services. As can be seen, a few contractors control most of the market for virtually every type of service.

In 1986, corporate concentration was lowest for laundry and linen services. In that market, three contractors controlled 48 per cent of the total dollar value of contracts held between hospitals in the private for-profit sector. In 1986, the most intense level of corporate concentration was found to be in the provision of food services by the private for-profit sector. In that market, five contractors held 75 per cent of the total dollar value of contracts. However, it should be noted that one contractor alone, Versa Services, held 59 per cent of the market in terms of total dollar value of contracts.

Turning now to corporate concentration in the Ministry of Community and Social Services, the only program for which we have data with respect to corporate concentration is in the field of service of children's boarding homes. There are notable distinctions in corporate concentration between the two parts of the program; that is, between extended family units and private boarding homes. Corporate concentration among extended family units was much higher in 1986 than it was among private homes for children.

Please note that it is not possible to indicate the significance of this finding, since information for the years previous to 1986 were reported by the ministry to be unavailable. While individuals and chain owners provide roughly the same number of beds to the market for private boarding homes, 33 chains control 112 beds. That is nearly 60 per cent of the total 189 facilities in operation for this part of the program.

However, it is of note that the top four chains provide only 15 per cent of the total capacity--that is, the number of beds--which currently exists in the market for private boarding homes. All indicators offered by the data show that the degree of corporate concentration is not high, therefore, among private boarding homes. This is not the case, however, for extended family units.

Of the 129 extended family units operating in 1986, 123, or 95 per cent, were owned by chains. The remaining six were owned by individuals. Whereas private boarding home chains control an average of approximately three facilities, extended family chains run an average of 14 facilities per chain.

This can be observed most clearly by the graph, which shows the extent of corporate concentration in this sector. Although the top four firms control over 80 per cent of the total capacity provided by this market, the top-ranked corporation, Ausable Springs, controls over 50 per cent of both capacity and number of facilities.

The last indicator we want to look at today is with respect to the regulatory mechanisms in both ministries. The only means by which for-profit activities in any of these programs may be monitored is through the inspections process. For this reason, we offer a summary by ministry of the status of information received regarding monitoring processes for each of the above-mentioned programs. Most of what I am going to say is in the handout of the summary of findings at the end.

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With respect to the Ministry of Health, our findings showed that in most cases we could get well-documented information about the inspection process. This was the case in the laboratories. We found that the laboratory proficiency testing program inspects each lab, and we found, interestingly, that when you compare the outcome of proficiency testing, commercial labs perform more proficiently--or there were fewer instances of nonproficiency in commercial labs than there were in hospital labs.

No historical data were provided regarding the complaints investigation process, which is conducted by the laboratory inspection service. The branch provided us with a list of its most frequently encountered problems with respect to complaints. Because this list was categorical rather than comprehensive, we could not analyse the trends.

Second, with respect to homes for special care, the inspection and monitoring processes were again relatively well-documented. The department provided a fairly complete historical list of data regarding inspections, violations and prosecutions for homes-for-special-care nursing homes and homes-for-special-care residential homes. We received no documentation with respect to the approved home program. No data were available regarding noncompliance or complaints.

With respect to nursing homes, the inspection and monitoring processes were well-documented, and recent attention was accorded the Woods Gordon report, which outlined some of that documentation. Most of our data were gleaned from that report.

Since 1984, the nursing homes inspection branch has maintained a central data bank on the outcome of nursing home inspections. That data revealed that there are marginally more violations for for-profit homes than there are for public and private not-for-profit homes, but we should point out that the difference is marginal.

With respect to hospitals, we received no data.

With respect to home care, the guidelines of this program appear to be very weak. Although the complaints procedure was indicated by the ministry and it was noted that the local home care program maintains information about complaints, the branch stated to us, "Since complaints are frequently of a personal or confidential nature, there is no requirement by the ministry to provide statistical data."

However, our experience with the inspection of monitoring processes in the Ministry of Community and Social Services was quite different than it was for the Ministry of Health. I will highlight some of that experience.

With respect to licensed day nurseries, the ministry reports that it does not keep a central database on the inspection process or on annual complaints received. We were told that paper files are kept by each consultant for annual review. This was mentioned by Cathy Fooks yesterday. As a result, no information was provided to us with respect to inspection procedures, violations or complaints.

With regard to children's boarding homes, the ministry provided us with a description of the criteria necessary for the rate review process. However, no information was provided to us with respect to licensing requirements,

periods of licensure or inspection process. No information was provided about noncompliance with licensing requirements or the outcomes of rate review procedures.

With respect to foster care, the ministry licenses each operator, not each home, with three-year licences. It describes the process as follows: "If a licensee is found to be in full compliance in the first year, the licensee may complete his or her own review in each of the two subsequent years." Needless to say, no information was provided with respect to records of noncompliance or procedures following noncompliance with requirements.

With respect to the family home program, accreditation, we were told, is granted to a family home after a six-month trial period. Thereafter, approval must be granted annually. No information was provided to us regarding the criteria approval, noncompliance or inspection procedures. With regard to homemaker-nurses services, we received no information.

Finally, with respect to homes for the aged, we were informed that the Charitable Institutions Act stipulates the criteria to be inspected in charitable institutions by the provincial supervisors. No historical data were provided, however, with respect to this inspection process, violations or complaints. However, the 1986 Provincial Auditor's report, after examining the records of 83 homes, concluded that the ministry appears to have no formal guidelines for the frequency, extent or reporting of inspections in homes for the aged.

To cite this report, they say: "In light of time pressures, lack of specialized qualifications and their perceived role as liaison persons, the program supervisors had not followed systematic inspection routines. Furthermore, inspection or other monitoring activities undertaken had seldom been adequately documented. The extent of documentation was left to the supervisor's discretion and normally consisted only of details of unusual incidents, but lacked any evidence of the extent of monitoring activities."

To sum up, I want to review our five major findings.

Ms. Fooks: May I clarify something? In some of these cases, the ministry has provided the criteria for their licensing.

Ms. Hannant: That is right.

Ms. Fooks: We have that in the blue binder.

Ms. Hannant: That is right.

Ms. Fooks: Second, in a number of cases they explained that because their inspections of programs out in the field are done through the regional offices, it would be difficult for them to get the aggregate numbers in the three months when they were trying to gather this data.

Ms. Hannant: That is right.

Ms. Fooks: I do not want to leave the impression that there is no inspection process, because there is a monitoring process. There are figures from the regional offices, but they have not put those together because it would take a lot of time. I understand this from telephone conversations with them.

If the committee wishes, we could have some discussions with the ministry as to how long it would take to get those aggregate numbers and what would be involved.

Mr. R. F. Johnston: Do telemarketing by using the phones.

Ms. Fooks: I want to make it clear that there are licensing procedures here. Monitoring programs are done through the regional offices and those people in the regional offices have a fairly close relationship with the people providing programs and they monitor them quite regularly.

They do not have the same kind of database that, for instance, the nursing homes inspection branch has now. When we asked questions such as how many violations there were, they could not give us the same kind of breakdown.

Ms. Hannant: What we are doing here is flagging. The decentralized nature of that ministry is part and parcel of the problem. None the less, when we asked questions, they sometimes said the information was in the field and was in the process of being gathered. We are simply reporting what was told to us. I am sure there are better explanations out there.

As of January 7, that was the status with regard to all these programs and the monitoring process.

Ms. Fooks: We still are due to receive a package from the Ministry of Community and Social Services.

Miss Stephenson: It is my understanding that about five years ago there was a ton of documentation related to at least three homes for the aged belonging to the Metropolitan Toronto region. Is it somewhere within the region of Metropolitan Toronto and therefore unavailable?

Mr. R. F. Johnston: It is pretty hard to find. There was a Metro report on Green Acres and others.

Miss Stephenson: Yes, that is right.

Mr. R. F. Johnston: It is available. I think there has been an update in the last year.

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Miss Stephenson: That certainly did highlight some of the directions that were supposed to be being pursued by homes for the aged so that you would have some understanding of the criteria of inspection or monitoring or whatever you call it.

Mr. R. F. Johnston: There has even been a report recently on contracting out within all the Metro homes, which is another whole question of privatization, etc. It was made public this fall. It is a mystery to me why information from the regions--there are not that many regions--cannot be made available to a central planning group within the ministry, which now exists. It went into limbo for a few years.

Oh, you want me to keep talking, Mr. Chairman, until you get back to your seat.

Miss Stephenson: Are you leaving?

Mr. R. F. Johnston: May I ask a question? One of the things that has interested me is whether there has been corporate interconnection in terms of the concentration question. We have nursing homes, which we know are involved in other kinds of businesses as well, but I am not sure whether, for instance, there are nursing homes available that are also involved in boarding home operations or whether there are any connections between these various kinds of things. Is any of that easy to pick out from the information you saw or is all that corporate interconnecting very difficult to document?

Ms. Hannant: There certainly seems to be some evidence of vertical integration. With regard to children's boarding homes, however, we requested that a corporate search be done because the type of information we report--this kind of corporate concentration--is based on a printout we obtain from the ministry that simply indicates the operators' names. It may not give you a true picture of who owns those homes, or what kind of interlocking relationship exists.

Until corporate searches are conducted for all of these, we will not have a true picture of vertical integration in Ontario. We know that some nursing home operations own labs, for example. There is that kind of vertical integration. Vertical integration, which I will refer to in my summing-up remarks, would be more prevalent in the programs administered under the Ministry of Health rather than under the Ministry of Community and Social Services.

Ms. Fooks: I agree. For the corporate search that was done in nursing homes, we got the companies branch to agree to give us its microfiche. Usually it charges for all the searches but because we had so many it agreed to give us the microfiche and not charge us. My unit had to do that. We did that ourselves, so it would have been physically impossible to have done every single operator we had a name for. We picked the nursing homes area because it was the greatest for-profit. If the committee wishes, we could do the same thing for the boarding homes but it would take some time.

Mr. R. F. Johnston: No, I was more interested in knowing whether that information had been easily discernible. For instance, I wonder whether a group like Viking Homes, which operates group homes, was involved in the boarding home business as well.

Miss Stephenson: It is not in the nursing home business and it is not in the lab business. They tend to be separate somehow, it appears. Those that are corporate structures within the area of responsibility of community and social services tend to remain within that orbit and those that are in the health orbit tend to remain within that orbit.

The only place I have seen any type of cross-fertilization, and it seems to be extremely limited, is in the homemaker or private home care program which has been begun by a couple of the people I was talking about. I know Diversicare, for example, has some in the field at the moment, but it is extremely small.

Mr. R. F. Johnston: Extendicare too?

Ms. Labelle: Yes. Without formal analysis, it is tough to say what the trend is, but clearly, companies like Extendicare are diversifying--which does not mean they become Diversicare--and are now into contract management for chronic care facilities in addition to ownership.

Miss Stephenson: Yes, but they have not gone in the direction of the provision of care within the community in the same way that Versa-Care has. They have gone in the direction of the administrative management of institutions rather than the other, as far as I can make out.

Ms. Hannant: The annual reports that we looked at for Extendicare expressed an interest in entering into the home care market. Again, that would be a trend.

Miss Stephenson: The former Deputy Minister of Health is one of its vice-presidents, so I am not at all surprised that is one of his interests. Whether they will go or not is--

Ms. Hannant: Something else.

Miss Stephenson: Yes.

Ms. Hannant: I thought it might be useful if I reviewed the five major indicators we have and then moved into more of a discussion.

First, as we have been arguing throughout, the experiences with for-profit activity differ between the Ministry of Health and the Ministry of Community and Social Services. Half of the 16 Ministry of Health programs that we reviewed currently have no for-profit activity. By comparison, where it was known, only two of the 20 Community and Social Services programs we reviewed have no for-profit activity.

Second, trends in commercial sector activity are difficult to compare between ministries because time-series data by ownership type were only available for three of the Community and Social Services programs. Where known, however, the commercial sector's share of the total market has remained relatively stable. With respect to the Ministry of Health programs, which display a significant degree of for-profit activity, the data available indicate growth in the level of for-profit activity over time.

Third, there seems to be a different nature of for-profit activities between the two ministries. For example, in Community and Social Services programs the classification of private for-profit is more likely to include sole proprietors, individuals and limited partnerships. More frequently, in Ministry of Health programs the term for-profit is likely to signal activity by large corporations, chains and multinationals.

Fourth, corporate concentration does not appear to be an issue for Community and Social Services programs. This is not particularly surprising in view of the fact that the Community and Social Services programs usually do not lend themselves to the generation of high profit margins. However, corporate concentration in services provided to Ministry of Health programs appears to be a phenomenon of greater concern.

It is not uncommon to find the top commercial corporations dominating a large proportion of services performed by the private sector and, in some cases, even the market as a whole. Furthermore, in programs provided by the Ministry of Health there is a basis for the development of vertical integration among corporations that provide health care services.

One can see that already in Ontario with respect to labs, nursing homes, purchase of services, home care, pharmaceuticals and purchase of counselling. All of these provide services to a largely overlapping client base.

This potential for vertical integration is less likely for Community and Social Services programs and services because the client base does not generally overlap and the nature of the services provided are very labour-intensive and do not lend themselves to this form of corporate organization.

Fifth, and finally, we noted important differences between ministries with respect to regulatory mechanisms which may ultimately have an impact on the monitoring of for-profit activity in Ontario.

Mr. Chairman: Are there any questions? I do not see any hands.

Mr. R. F. Johnston: I do not have any questions. I was more concerned about the data we have received, but I see most of them are comprehensible and do not need any basic questions. As Dr. Stephenson was saying, we do know why some of these things have happened in labs. We know why they have happened in certain Community and Social Services things because of policy changes in the 1970s around children in need of protection, that kind of thing, but the statistics are all fairly clear.

I was just looking at a letter to you from Extendicare that we have to look at. I will just get Roberta here to have a look at it. There is a question out there on vertical integration. They own Paramed. I did not know that. That is a home care delivery service which is growing in the market at the moment. It is American-based. I always thought it was an independent group. They are actually involved in home services, as well as Versa-Care.

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Miss Stephenson: Primarily below the border.

Mr. R. F. Johnston: Yes, but Paramed itself is growing here.

Miss Stephenson: Yes, it has begun. The interesting concept is the multinationals which have become involved in this. The primary multinationals are of Canadian origin, which is an interesting new development.

Mr. Chairman: May I inquire whether the reason there is more corporate concentration and multinational interest in health care is that they are able to understand that, whereas perhaps they are not able to understand our Ministry of Community and Social Services programs? Is there any indication of that?

Ms. Hannant: I do not get any indication of that.

Miss Stephenson: It is not a matter of understanding at all. It is, in fact, that every single governed jurisdiction has different rules for community and social services, but the rules for the delivery of health care are pretty much the same all over. They are pretty much the same whether you are in the Middle East, where there is absolutely no social service program at all, as they are here. So the multinationals can expand into developing countries very well in terms of providing health care programs, but they would have a terrible time if there were multinationals in the social service program expanding into Islamic countries, where the social services would be based on a totally different foundation from what they would be here. It is not a matter of understanding; it is a matter of total difference.

Mr. Chairman: That was really the question I was asking. Is that the

reason they zero in on health? Is it because, as you say, health here and health every place else is dealt with in a similar fashion?

Ms. Hannant: Their profit margins have a lot to do with it too. I would be hard pressed to think of a multinational that would be interested in providing a family home program at \$20 a day. Certainly, the room for profit is much greater in the field of health care than it is for social and community services.

Mr. R. F. Johnston: Most institutions in community and social services are of a smaller kind as well in terms of the actual physical structures, such as homes for the aged, which have been run traditionally by the municipalities or charitable organizations. Only recently, as is pointed out--and I think it is an interesting thing for us to look at--there has been the development of the satellite homes. They are almost all for-profit, even though they are linked to municipally run homes for the aged. That is an interesting development.

The other one that I think is fascinating to look at--and there will be no data on this at all, because it really has not happened--is the social policy change around day care, which looks as if it may be developing here and in other parts of the country around an encouragement of the commercial sector by providing them with subsidized rates and that kind of thing, which we have in the nonprofits now.

If that occurs, we do have some structure already out there in terms of multinationals involved in day care provision. They have not found it profitable enough, because of the lack of guarantee of subsidized spaces, etc., here and in Canada, to move into that. If that were available to them, the development of that multinational sector might be quite interesting to watch.

Ms. Hannant: Mini-Skools, which is a subsidiary of Kinder-Care in the United States, currently operates in this province. We had some rough numbers but we could not confirm them, because they were not linked to ownership. Certainly, they are operating here. Some argue they are leaving the market.

Mr. Poirier: Also, there was the case of Versa Services, which went into the day care market, purchased one day care centre and sold it a year or two later because it was not seen to be profitable. It did not seem to be worth while for them to get heavily involved.

Mr. R. F. Johnston: That may very well change. I am just saying the two factors, social policy differences between the regions of the country or internationally, plus the kind of scope for profit and size of many of the institutions that are developed under Community and Social Services, have made them less attractive. One can now start to see a few changes in social policy which might switch that trend. That is why I was interested in the crossover thing, which Dr. Stephenson has rightly said does not seem to have happened much as yet, but might.

Mr. Chairman: In a word, a market is being created--the activities of a changing environment vis-à-vis jobs. Both parents being in the job field around the world are creating that potential market for daycare services to become a very large for-profit area.

Mr. R. F. Johnston: One of the ways of responding to that is to allow that sector to develop, yes. That seems to be something that is being

discussed here in Ontario and nationally now, although the national policy or position really has not come forward from the parliamentary committee, let alone from the government as yet, so we really are not clear where that is going.

Miss Stephenson: In February?

Mr. R. F. Johnston: It is coming down in February, yes. It is the first or second week, I cannot remember.

Mr. Chairman: There may be something, I do not know whether it would be worth while to the committee, but perhaps it could be gathered; there was a very excellent program on Peter Gzowski's show this morning. Women from all over Canada were discussing the question of day care and the quality of day care. It was very interesting. Apparently they have now had significant time to assess the effect--this might be beyond our parameters, really--of day care on children, vis-à-vis an update on day care and good day care versus bad day care. I do not know whether we would want to get into that or not, but it may be germane to what you perceive is perhaps going to happen, and I am inclined to agree with you that it is going to happen.

Miss Stephenson: One could bring Jerome Caggen and Burton White up here and they can argue it out. The arguments continue because there is still great diversity of opinion as a result of what is perceived to be the characteristics. I do not think they have really pursued any of those subjects, if we can call the little people who are involved that, to full adulthood as yet. They really do not know what the long-term effect is, but they do know what the effect is in certain learning capacities within certain groups.

There is not any doubt at all that quality day care in the socioeconomic disadvantaged group is a very great benefit to them, particularly in terms of their learning in school. We also know that highly structured and highly organized day care for kids in relatively normal circumstances, whatever that is, may in fact be an impediment to the learning process, when they really do begin the educational process in school.

Mr. R. F. Johnston: But the question of quality--

Miss Stephenson: What is quality?

Mr. R. F. Johnston: --is begged by some of these things, whether we are looking at nursing homes versus homes for the aged extended care provisions. The question of quality and commercialization is obviously one we will have to deal with. No matter what the answer comes out to be, that is a question.

Miss Stephenson: What is being defined as "quality"? This is one of the major problems as well.

Mr. R. F. Johnston: What is our plan now, Mr. Chairman?

Miss Stephenson: When do we get whatever other direction we are supposed to be getting from our friends in Hamilton?

Mr. R. F. Johnston: These two here?

Ms. Labelle: We hoped we would have had more time with the committee

to digest these things, but we certainly want at some point, after we have given Research Innovations a chance to respond to any questions, to try to synthesize the data and attempt to forecast the success of various situations to decide upon high-priority areas to pursue for phase II, as well as to decide upon, very roughly, the strategy for drafting out the interim report, which we would like to get to the printer as early as possible.

Miss Stephenson: If, in conjunction with this, there was some critical examination of the reasons for what appears to be certain directions having been pursued in some of the areas rather than others included, and we could understand what those reasons were, then I have a feeling we would be better able to assess whether we should be pursuing intensive examination in certain of those areas or whether we would be better to concentrate on others.

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I have difficulty in saying we must go in that direction because the trend is so highly one way, when there are very solid reasons for that trend having gone that way at the present time and there may be other areas in which there is not any such trend that we can perceive, which may be much more important.

Mr. R. F. Johnston: There is a problem of digesting what we have received in terms of the bulk of the data, but today it may be important for us, at least, to try to do the synthesis today of what we have to go away with. We are then going to need one other session to sit down and decide on two things: the nature of the interim report, what size it is going to be, what we are putting in and putting out; and what our priorities are going to be for the next stage and hold that for another day, if possible.

I know it is very hard to book committee time these days. My own committee is feeling a bit of pressure on that, but that would be a better way of dealing with it, if we handle any further questions around the data, then go to you two to talk about what we have received today and wait for another day to make our decisions on it.

I am developing a bias I can feel already, which is that no matter which we choose as concentrations in the next hearing--and I presume we are not going to limit where we go--we do one from each ministry because there seems to be quite different kinds of information coming forward and it might be good to balance where we go with that.

We should make that decision some time next week, if we could have a meeting. Debbie and I were talking about it, and maybe the only time available is next Thursday morning when there are not many other committees meeting. That would be in the ordering of this. I would like some time to let this settle in, after hearing what you two have to say.

Mr. Chairman: We were looking at Wednesday afternoon after routine proceedings but I notice today, time permitting, we were to consider the interim report in camera. I do not know whether we are ready to do that.

Miss Stephenson: I thought we were going to hear from the experts about what they perceived as significant in these data which might be of assistance to us.

Dr. Stoddart: First of all, I think we should say that just getting a picture like this is a formidable task, but Research Innovations and Cathy

Fooks have done an excellent job of preparing an inventory of a situation in Ontario which, up until now, we could not even talk about and have some numbers. It is not complete, for good reasons, but we do not want to underestimate how much that has produced and the fact that we finally have a snapshot of the extent of for-profit and not-for-profit private activity.

Although we have seen the preliminary report from Research Innovations, I must admit we are very much in the same ball park as you in the sense that it takes some time to digest this. I tend to agree with Mr. Johnston that we have some preliminary thoughts we would be happy to share with the committee about where things might go.

The major issue before the committee, as opposed to research staff, is to select some criteria, certain program areas on which you want to focus. There are all sorts of possible criteria. What I hear you saying is that merely knowing that the share is this, or that it is increasing by X per cent may not be a criterion or it may be only one criterion. When people trade off criteria or trade off what they want to look at, that requires discussion.

I do not know whether you want to have that discussion now or later or whether you want to have it in camera or not in camera, but those seem to me to be decisions the committee will have to take before we go too much further. I am not sure whether people have had a chance to digest this or whether they have any other questions for Research Innovations. It is unfortunate about the scheduling because there were six two-hour periods originally booked for this and that was the plan of attack. If we really want to compress that, then the next high-priority issue is for the committee, such as is here, to decide on criteria for zeroing in on.

Mr. R. F. Johnston: In terms of the ordering of things at the moment, what I am hearing is that we should find out whether we have anything more for our data collectors and make sure that is as covered as we can get it. I would like to hear your preliminary responses to this and then I would like us to adjourn and try to find another time.

That would give me a chance to talk to Mr. Cooke, for instance, about this and to my caucus and for other people to be able to talk about the kind of criteria we would like to look at. Then we could come back next week and try to have a working session, first on the criteria and then on what our next steps are, if we can come up with them.

As far as being in camera or out of camera, this kind of discussion is an obvious, healthy one which can be held in public as well as in camera. I do not think we need to go behind closed doors to discuss that. I suggest that we first find out a bit more from our data collectors. I do not have any further questions at this point.

Mr. Chairman: There is just one point. I have been receiving briefs from everybody from soup to nuts, if I can put it that way, and I have been referring them to Debbie. These people all have a perception that they are going to be able to come forward and give testimony.

We have chosen not to look at those briefs, so they do not affect how we write the interim report. But if we write the interim report just on the basis of what we have heard now, we may very well have to eliminate a lot of those people in terms of whether they may appear before us. They may be outside the parameters of whatever the interim report may say.

Ms. Labelle: My understanding of the interim report is that it is a reporting of what is going on. It is an inventory and, as such, it does not delete or highlight, other than trends that obviously emerge. It certainly does not delete anything.

Mr. Chairman: Does it limit?

Ms. Labelle: No, it really is an inventory. As Greg said, it is a snapshot of our health and social services system and the extent of privatization, where it is concentrated and what services and programs it offers.

Phase II then goes on to pick the high-priority areas. One of the tasks before the committee is to decide, given that we now have this view of what is going on, where we concentrate. The interim report, as I saw it--and I may have the wrong understanding of this--does not limit at that point. It does not start concentrating; it merely provides the overview of what is going on. I do not think it would necessarily eliminate anybody from coming forward until the committee sits down and decides what it thinks are priority areas for examination in phase II.

Miss Stephenson: It might outline the directions we think are appropriate for further study by the committee. I hope that is what we would do.

Ms. Labelle: That is exactly what is supposed to be in it.

Miss Stephenson: That is simply yet another inventory of the areas we think are significant. They may have precious little to do with the point which has been emphasized in all the research we have done so far in terms of simply categorizing whether something has been privatized significantly. We might be moving away from that direction and looking at something else.

I hope I did not give the impression I was in any way denigrating or minimizing the value of the information we have received to this point. It is phenomenal that we have this in hand at this time, because it has never been in hand before. There are great gaping holes, and this committee is not going to be able to solve those at this stage of the game. It may make some recommendations, but the solutions will not necessarily come from the committee.

I feel very strongly that there are some sheets, as Cathy decided yesterday--and there may be a couple of other sheets as well--we probably should not include in the report because they are so absolutely invalid.

I would hope that what we would do is have sufficient time to think seriously about the kinds of directions we are going to pursue after receiving all this. At this stage of the game, we know where certain things are happening; we do not know whether a quality program or the best, most efficient or effective kind of program is being delivered in this way or in that way. I am not sure how we find that out specifically from what we have right now, but I am sure you are going to be able to help us determine that.

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Mr. Chairman: Do you want to respond to that, Dr. Stoddart?

Dr. Stoddart: I am not sure whether I am stopping that gavel from coming down.

Mr. Chairman: No. I cannot smoke so I have to do something with my hands.

Miss Stephenson: So he waves them.

Dr. Stoddart: Again, I can speak only from the original research plan. In terms of that plan, phase II of the research was to parallel phase II of the committee's deliberations so that the committee could become clearer on the areas and directions it wanted to focus in on, and therefore it might be possible for us to look at certain pieces of literature of an evaluative nature as opposed to what was done in phase I, which was entirely descriptive.

You may recall that we talked about the difficulties of doing comparisons. We talked about some strategies back in the early days; how we might go about that, who we might commission to get some memorandums done on certain things and so on. That is all still possible, but obviously, we have not charged ahead and done anything on that because, with the exception of one or two areas that seem to come up all the time, it is not entirely clear how the committee wants to go forward.

In terms of the research that needs to be done--and it needs to be geared up for fairly quickly--it would be helpful if some sense of the committee's timetable were known and even if some initial discussion were held on the directions, the criteria and so on, maybe next week or the week after.

I suspect that some compromise about not limiting or limiting could be reached in the interim report such that it does not exclude people who want to come before the committee and speak to certain themes, even if that program area has not been one where the committee has said, "Obviously, we have to do something here." The interim report may very possibly be able to say, "We are going to look at X, Y and Z, but that does not prohibit other folks from coming forward, and we will consider those as they occur." That is one suggestion.

Miss Stephenson: The simple announcement of a select committee on health brings everyone out of the woodwork. Everyone who has any type of advocacy or defensive role at all wants to come and say something about it. I do not think this committee is ready for that at this point. We have to decide where we are going to go first, before we start inviting people who have a point of view to come and talk to us about it.

Dr. Stoddart: And when you might go there, from the point of view of trying to prepare, similarly to this sort of descriptive exercise, some evaluative exercise which is going to be even more difficult, it would be very helpful to the research staff to know--

Miss Stephenson: In advance.

Dr. Stoddart: --when you might get there.

Mr. Andrewes: I am not sure I can contribute a whole lot more than what has been said other than a personal view and a view from the standpoint of the organizational aspects of this committee. At this point, I do not want to start sending out signals that certain points of view are not welcome, but at the same time, I think we have to look at a timetable that lets us work efficiently. We do not have a lot of time in the interim session. I do not think it is going to serve our purposes very well to sit here day after day listening to a plethora of points of view which we then have to distill.

We need to be directionally focused. Then we should look at some of the individuals or groups who have approached us and compile a list. That list may include inviting certain people to come before us who have not yet indicated a desire to do that. That would be more helpful than just being blotters for the points of view of every advocacy group in the province that finds the time to make a presentation.

Mr. R. F. Johnston: We are talking at cross-purposes. It seems we are all coming around to the same type of thing. I guess what we see going then would be for us to try to decide how much of this goes into an interim report, what kind of a synthesis of all this information goes into an interim report as compared with the direction we are going to go in. We need to do that within the next two weeks, because the end of session could be on us by February 12 by the looks of things at this stage.

Once the direction is set, then we need to have an idea of what is a rational amount of time to leave for researchers to do work prior to us holding hearings and inviting, or whatever, and how much time we would actually then be able to have for those hearings during the break. It would probably have to be some time in late March through until we come back at the end of April.

Mr. Chairman: April 21, I have heard, according to the press.

Mr. R. F. Johnston: We might be limited to around a month or so of actual hearing time if that does allow us enough practical time beforehand. It seems to me we have to--

Interjection.

Mr. R. F. Johnston: I had forgotten you were going to be away. We may have to make the decision next week, or, at the latest, early the week following, or we are not going to be able to set things in motion fast enough for us to be able to do anything particularly productive in the interim.

Mr. Chairman: I know we have gone through things where there was either a for-profit or not-for-profit. There was one category on the summary from Research Innovations, category two, on which I was very interested in hearing comments from witnesses.

If the interim report is going to be framed around the question of corporate concentration of changes in trends of profit and not-for-profit, as opposed to the perhaps broader area of how services are provided, for instance, category two--we are going to deal with category two, I hope, in the hearings--I would certainly like to hear from a broad sector of witnesses in that regard.

Otherwise, I think you just come out of it with a lot of numbers, some trends, and then, hopefully, an ability to be able to say, "Which ones provide quality and dollar value and which ones do not?" and you try to adjust according to that. To me, that would be a very boring exercise.

Mr. R. F. Johnston: Clearly, that is one of the things we have to decide when we meet again. Do we want to, for example, choose one very limited sector, such as nursing homes, and just deal with that sector to see what we can learn and what sort of methodology we can develop around that? Or do we want to do any number of things, one of which could be to look at areas that are totally in the not-for-profit area at the moment versus programs--I do not

know how we would do this exactly--which are for-profit and try to do some analysis of the two in terms of why the social policy has made the one go the way it has, what is the quality of care, etc.

There are a number of options for us to look at. I do not think anybody is trying to rule that out just because, statistically, the emphasis of the information to us has been on corporate concentration. After you have said that none of these are for-profit, there is nothing else to say about the commercial development of them. For the data collection, that is all we really would have expected. That does not rule out what we might look at, in terms of how we go about it. I gather there are no other questions.

Mr. Chairman: I was going to ask that. I gather there are no further questions of Research Innovations.

Miss Stephenson: Because we have made assumptions and those assumptions have been accepted by Research Innovations related to the definitions--with which I have some difficulty, I can tell you--I think what they have done is excellent, and I am very pleased to have it. Thank you.

Mr. Chairman: Then we will perhaps have something from Roberta Labelle and Greg Stoddart. I do not know whether you want that in camera.

Mr. R. F. Johnston: I prefer we do everything just as a regular committee.

Miss Stephenson: Are we doing something secret?

Mr. Chairman: I am just going by the list in front of me.

Clerk of the Committee: Can I explain that? You will notice it says on your agenda, "Interim Report--in camera." The reason is that if you were going to discuss any of the content of the interim report, as is usual, a committee will discuss content of a report in camera.

Miss Stephenson: I am not sure it--

Mr. Chairman: In other words, the press should not hear about it before the Legislative Assembly does.

Interjection: They do anyway.

Mr. Ferraro: It should all be in camera so we cannot get served with writs.

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Miss Stephenson: I am not sure even that would help. Stikeman Elliott does not seem to be particularly interested.

Mr. R. F. Johnston: The point is we are not going to be writing a report at the moment, so why do we not have the discussion on preliminary responses from our researchers this evening?

Miss Stephenson: We are not going to be talking specifically about what we want included in the report right now.

Mr. Chairman: Okay. Why do we not let either Ms. Labelle or Dr. Stoddart--

Miss Stephenson: Or both.

Mr. Chairman: One at a time, though, for Hansard's benefit.

Ms. Labelle: Perhaps what we can do for the remaining time today is provide you with some suggestions about the format and structure of the interim report and how we might proceed in finalizing it, and then leave you with some potential categorization or criteria for assessing what the high priority areas are for the next phase.

Obviously, we had not wanted to do that unless the committee asked us to because there are all sorts of criteria that we are not going to be able to take into account that you are aware of. However, we can certainly provide you with a framework that you can perhaps go away and consider, so that when we meet again we might be able to identify those areas quickly.

On the issue of the interim report, we have several options available in terms of what gets included and how it is presented. We had thought one possibility might be to provide a summary at the beginning, as Research Innovations and Ms. Fooks have both done, about the highlights indicated by the data; then, provide the data as a part of the report, comprehensive so that the report really does take on the nature of an inventory, so all programs are included--nobody gets excluded--and so that agencies and ministries that have provided us with information have a chance to see where we do not have data, and perhaps one final pass at filling in blanks; then, have a third section devoted to the future directions of the committee, essentially mapping out phase II, identifying some high priority areas without necessarily excluding others.

It would obviously be a lengthy report. A second option would be to combine the first part which is the highlights with the third part which is future directions, and produce the inventory as another report of the committee in addition to the Research Innovations report and Ms. Fooks's report.

A third option would be to include it explicitly as an appendix. If you want our opinion, parts I and III are indispensable. We cannot do without them. The second part, which is the inventory, contributes to an area where very little is known. It is a contribution to the field. The ministries would probably very much appreciate a summary, since they do not do it. The people researching the field would very much appreciate that and it would also recognize the contribution and the amount of hard work that has gone in on behalf of all our researchers. They might be various options you would want to consider.

Then the discussion comes down to what the highlights are and what should be brought out and what the future directions are. We hope the future directions will be resolved in the next meeting. The highlights are not likely to be subjective. They are just documenting the evidence and in that case we have a couple of options in mind.

Ms. Fooks is quite willing to take the lead and cull from the data what the highlights were and then perhaps meet with the steering committee so that we would not have the time constraints and problems of getting the full committee together. We could have a draft interim report ready fairly quickly to provide to the full committee. If that goes on schedule we can then meet with the steering committee on the highlights, have Ms. Fooks prepare the body of tables and that sort of thing, and meet with the committee some time in the

near future in the next week or two on the third part which is future directions.

Mr. Chairman: Can I interrupt for a second? I seem to recall having received some sort of memo that you were going on holiday.

Ms. Fooks: No, I sent you a note saying if the interim report was done--forget it. It is not done, so that is by the wayside.

Mr. R. F. Johnston: What you are saying makes some sense. I am just thinking out loud around the question of getting all this data out there to the Legislature. These are public documents now in the sense that they are filed with the committee.

I am wondering, for our purposes, rather than having the whole thing go as a compendium, an appendix or the middle part of the report, rather than putting it into the whole report and sending it in, whether it is better to make sure that we make a number of these available to interested members of the Legislature, researchers in the field, the ministries and that kind of thing. It is not traditional within the--that is not right; it is, from time to time. I am thinking about the select committee on company law and others. Everything they ever did went into their reports.

Miss Stephenson: In the social policy field it has not been traditional, and I think this is a marvelous opportunity to be untraditional and move in the direction of really including all the research that has been done to document this information, which has never been in one place before. If we leave it loose like this and simply say to people, "It is all available and you can have it," nobody is going to look at it, except those people who are really interested.

Mr. R. F. Johnston: There is a problem.

Miss Stephenson: They are not going to look at the totality. They will look at the parts they are interested in and not the rest of it. I would like to see the appropriate collation of the research that has been done included as an integral part of the interim report. I think that is the foundation upon which we move forward from there.

Mr. R. F. Johnston: What are the logistics of that in terms of the time it would take? I presume that means somehow melding these two things we have received into one thing, rather than just having both documents put in and then getting all that printed, besides our decision-making. Does the clerk have any idea how long that would take?

Clerk of the Committee: If I know that printing is what the committee is going to decide to do, then the printers can be waiting with their materials all set to go. It would only be a matter of a week to get it printed and bound.

Mr. R. F. Johnston: We would want to have it in the House before we rise.

Miss Stephenson: That too is something we talked about briefly yesterday. There is no burning necessity to have it delivered to the members of the Legislature before the House rises because it certainly can be delivered to the Clerk of the House between sessions--if that is possible. My concern is that I am not sure we need to go in the direction of the very

expensive printing process. I am sure there are other ways to make sure all this is available if that cost is going to be prohibitive.

Clerk of the Committee: If you want to make it an appendix or an addendum to the report, it can be done. What we can do is copy what is necessary from the information that is here and provide that as an addition to the report.

Miss Stephenson: Are you saying we cannot produce an interim report that has not been subjected to the art of the printer, that we cannot produce a report that is simply typed, Xeroxed and bound together in an appropriate fashion to be delivered to the members of the Legislature and whoever else is going to get it?

Clerk of the Committee: If you want to do that; the only thing is that, in fact, it might be more expensive.

Miss Stephenson: The question was raised by Mr. Johnston whether it is going to be prohibitively expensive to include all that documentation. I think we simply find the way that makes it least prohibitively expensive and deliver it.

Clerk of the Committee: If that is what the committee wants, what I will do is decide which is the least expensive and more expedient method and use that.

Ms. Labelle: Further to Dr. Stephenson's point, the information is interesting, obviously, for what it shows, but it is also quite interesting for what it does not show and for identifying the gaps. That is a very important process when it comes to evaluating evidence. I think it makes a contribution in that respect. On another point about expediency and all that, Ms. Fooks and Research Innovations have worked together to design a format that helps to integrate the two findings, so it is not that we have two very dissimilar formats and reports. It was always intended that at some point they would be meshed together to produce some portion of the interim report.

I have spoken briefly with Ms. Fooks about how long it would take to produce that sort of a report. Although she probably does it at superhuman speed at times, there are constraints. My experience in the past has been that the greater constraints might be in getting part III out, which is future directions, given the scheduling of the committee and such, than it is with actually producing the guts of part II.

Miss Stephenson: I agree with that last statement.

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Mr. Ferraro: With the committee's indulgence, may I be so bold as to ask a question? As the committee knows, I am a substitute and not a member of the select committee. I am just curious and speaking out of ignorance. I am sure there are many years of experience before me that have dealt with this problem in one shape or form in the past. I look at the report that you have here, an analysis of the trends and so forth. Specifically, in that this is a select committee on health, is the committee mandated or predisposed to look at one thing that has been bothering me in particular? Why do we have two different ministries looking after nursing homes and chronic care as opposed to homes for the aged? Is that of significance or am I away out in left field and should shut up?

Mr. Chairman: No, that probably could become part of the--

Miss Stephenson: Appropriate integration is one of the objectives of the select committee on health, as a matter of fact.

Mr. Andrewes: It is an interesting observation, even to the extent that the method of collecting data, management, the styles, the directions--

Mr. Ferraro: Notwithstanding the economics and the degree of care.

Mr. Chairman: That would probably come within the framework of our examining what is there, how it is being delivered and how it can be better delivered.

Miss Stephenson: It is certainly within the terms of reference of the committee.

Mr. R. F. Johnston: For reasons of omission and submission, we seem to have a consensus that we want as much of this information to be on record as possible. as a member, I do not particularly want to be involved in the process of trying to meld these two things. I would be happy to leave it up to Ms. Fooks and you two to make the decisions on that. Our role would be involved in highlights and in direction.

Miss Stephenson: The steering committee will take a look at highlights and the future directions and will make recommendations to the committee.

Ms. Labelle: In terms of future directions, perhaps this would be a good time to identify for you some possible classifications of the types of services and programs that we have looked at today, so that you can go about the task of identifying the high-priority areas for phase II.

Dr. Stoddart: I notice you have left me the easy part.

Ms. Labelle: I have to go.

Dr. Stoddart: These are very much in order of first reflections. Since you so nicely left it with me, I would like to start with some observations which, let us say, are joint. The first observation--

Miss Stephenson: It is the easy way out, mind you, but that is okay.

Dr. Stoddart: I got the final report more or less when you did. The first observation I have, making a judgement call on this, is that when you see the data and take the whole categorization, one through five, as a group, there is less for-profit activity going on that seems to be generating concern than would have seemed to be the case to a somewhat informed observer such as myself at the start of the formation of this committee.

Simply looking at the evidence now, if we look at the amounts that are increasing or the shares that are large, on those criteria alone there appear to be four areas, nursing homes, homes for special care, children's boarding homes and child care, that you would pull out and say, "Certainly, these would be part of what we would want to announce as being subjects of hearings and further research in phase II."

A second observation would be that--and I am not the person to tell this

committee what its constituents seem to care about--my reading of the clipping service and the things I have come across from the research staff, the legislative library, the committee members and so on, is that it appears that many of the concerns that are surfacing in your constituents are captured in those areas.

The areas that would be identified if you were to do that analysis seem to be coinciding with the areas you have indentified from a statistical analysis of the magnitude of sectors and the changing expenditure trends, growth, etc. At the end, I would not mind if Research Innovations would comment on that observation because it has done and is more knowledgeable than just doing the statistical inventory that is read quite widely in this field.

Mr. R. F. Johnston: Only children's boarding homes do not get that. They are very invisible.

Dr. Stoddart: Okay.

The third observation would be that, having said what I just said, I certainly recognize that there are other occurrences, sometimes unfortunate occurrences--we might label them incidents--in other programs outside of that set. They may by themselves justify some interest or some further statements on the part of the committee, but if they occur in programs outside of category 5 or 4, I am really not sure what the committee would want to do about that. It could treat them on a case-by-case basis; I do not know.

Finally, the fourth observation would be that there are a couple of other questions that are not necessarily well addressed by this approach. These are questions such as: "What new markets are being created by changing social forces? What are the potential avenues of vertical integration we might want to be interested in?" By their very nature, they are not going to show up in historical trend analysis because they are about to happen. That is something I think this committee should be alert to in its digestion process; it probably already is.

Those are my initial observations. I tried to keep them to a small set about the statistical findings. I have some more comments on criteria, but maybe at this point we can see whether Ms. Labelle wants to add anything to that.

Ms. Labelle: No.

Dr. Stoddart: Ms. Hannant, would you like to comment on your reaction to my observations based on the fact that you folks have been immersed in these data for four or five months now?

Ms. Hannant: Yes. Obviously, we did this type of categorization not just so we could make sense of a whole lot of data, but also because the data started to make sense. Virtually every case in the top category is important, and you would not want to exclude them out of hand. What for us is important--and this is by way of remarking on what Dr. Stoddart was saying about new markets and vertical integration--is that we begin to see that in some type of embryonic form in category 4, especially with respect to the home care program.

Given the experience in the United States, I think it would be very interesting for the committee to look at developments there, more than just simply looking at the numbers, because when you look at the numbers, in fact, they are not that large. It is the growth that is large.

Hospitals and purchasing of services are another case. It is a field that is not necessarily growing in real terms, but it certainly is in absolute terms and it has made certain people very concerned about that. That is another way these findings could be looked at; that is, what is happening within institutions that have normally been defined as public. Even though these hospitals, for the most part, are private and not-for-profit according to our definitions, they are still considered part of a public health care system.

What is happening to that system, as we have found, is that more and more private for-profit activities are occurring within such a public institution. That is why we highlighted hospitals as a case in point, and I think an interesting case in point, where the internal operation of public institutions is becoming increasingly privatized.

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We really have two phenomena going on. In some instances, we have the privatization of a whole service, and then we have the privatization of public services which are still being operated much the same and in the same sector, but their internal mechanisms are beginning to see signs of privatization. We have not looked at the effect of any of this. We have simply drawn out as much data as we can that indicate that there is change going on.

Mr. R. F. Johnston: I do not want to get into a debate about this matter tonight. Some of these things are obvious areas which are politically hot in terms of interest. Boarding homes would not be because, traditionally, they have been totally invisible. However, in one way or another, there is some public sensibility around the others.

The notion to look at the trends in the United States does make some sense, especially in the health care field; the multinational activity seems to be more prevalent there than in the community and social services area. From my perspective at the moment, I am not sure it is an immediate thing I would want to spend a lot of time on.

Miss Stephenson: It is not as relevant.

Mr. R. F. Johnston: Quite possibly, but it is something to keep in mind. I would be interested in hearing any other comments to throw into the hopper at the moment. Are we going to try to set a time, or are you going to try to find a time for us to meet again, Debbie?

Clerk of the Committee: I would like to try to set a time, but if that is impossible, I will try to find one.

Mr. R. F. Johnston: Okay. That is all.

Mr. Chairman: Anyone else? What do I do next?

Miss Stephenson: Dr. Stoddart wants to say something right now.

Dr. Stoddart: I am not sure if I want to say something, but I feel an obligation to make some comments on criteria since I mentioned that I would.

I think it is going to be difficult to do this in an explicit way. That is my first comment. It is a difficult process for the committee, but it is an important one. Let me suggest some criteria you may want to consider.

Obviously, issues of the total share of the sector or growth in the sector of for-profit activity might be one criterion which makes it of interest as an entry point. Obviously, that is not the only criterion.

This is purely my opinion, but it seems that a committee like this should be looking at protection of the public first and foremost and the extent of interaction between for-profit activity and areas in which the public is either not able to evaluate the quality of the service it is getting or, if it is able to evaluate it, it is not able to do anything about it.

I would want to try to use that as a brush to cut across some of these statistical areas and say, "In which of these areas does it look like consumer information or ability to act on that information is an issue," and use that as one way of cutting some of this data to suggest where we might start looking at things.

Another obvious possibility for a criterion, aside from quality and protection of the public, is the relative efficiency or relative cost performance of providing the same services in cases where they can be publicly or privately provided. I am thinking of measuring the total social cost, not just the cost to the ministries, but the total amount of resources that society commits in a model where the services are provided publicly versus a model where they are provided privately.

That is very difficult but that seems to be a criterion. If we thought there was an issue, not of quality but of total resource commitment--given if it was provided publicly or privately--that might also be a criterion. In many of these cases, the provision model is separate from the financing model. That may mean that the total resource commitment or social cost is pretty close to the public cost, whether they are privately or publicly provided.

There are two other issues. I am not sure how they fit into criteria. I think digestion is required and I do not think they are uncontroversial. I will raise them anyway because it is important we get some of these things into a hopper and let them bounce around. One is, if we are talking about the committee eventually recommending future directions for commercial for-profit activity, we are going to have to grapple with the issue of where the capital comes from for some of these facilities to provide services if it does not come from the private sector. That is an important question. We are seeing growth in future capital needs in many of the areas we are talking about here. It is not clear where that capital comes from.

The Acting Chairman (Mr. Ferraro): Can you expound on that a little for me? It is not the private sector, it is the public sector. What do you mean specifically?

Dr. Stoddart: For example, suppose the committee were to say that in its wisdom it recommended restricting the role of private for-profit activity or even private not-for-profit activity in favour of public provision. That has some pretty serious implications for capital financing, for estimates, for taxes and so on. We cannot talk about those things in the future in the committee without keeping that in mind. I know the health sector better than the social service sector, but the issue of capital financing in the health sector is a major issue.

Miss Stephenson: It is a question of comparison. When was the new home for the aged built and who provided the capital for that, which was public capital, municipal and provincial, as compared to when the nursing home was built? At present, the nursing homes are entirely privately capitalized.

Mr. R. F. Johnston: One home for the aged in the last X years. I cannot even remember how many now.

Miss Stephenson: Two.

The Acting Chairman: There has been some federal government involvement in nursing homes though. Was there Canada Mortgage and Housing Corp. financing?

Miss Stephenson: There has been CMHC financing in some private not-for-profit nursing homes but not in the private nursing homes.

Mr. R. F. Johnston: Yes, it is one of those.

Dr. Stoddart: To summarize the criteria, we might want to start out thinking about--and I suspect the committee will add a lot--the size and growth of private for-profit activity in a particular area. There are two major performance issues, one of which is quality as it relates to protection of the public, consumer information and the ability for consumers to act on that information. The other is primarily a cost issue, assuming there is equivalent quality. Aside from performance, we need to think about providing for future service capacity, which is a separate dimension. That is all.

Miss Stephenson: And they have different directions.

Dr. Stoddart: It may be related. One needs to sort out the performance issues first because, presumably, the committee wants to be on solid ground, having assessed performance, before it talks about the model under which future capacity might be provided. That is all I would like to say today to get the process going.

Miss Stephenson: I was trying to say that future capacity may not be in the areas in which there is a capacity now. New areas may be developed for the provision of service, which would be entirely different from today.

Mr. Andrewes: I have a problem with your term "protection of the public." It almost suggests a negative connotation that we are here as a watchdog. I feel we are here to suggest ways in which the service can be delivered, the quality and efficiency can be improved and so on, without switching it over to the negative view of being the guardian. Directionally, we are going down the same path. It is just that we are looking at--

Mr. R. F. Johnston: There are the two sides of the coin. One is that a lot of these groups we are dealing with are vulnerable consumer groups, the frail elderly or handicapped kids or whatever it may be. Therefore, there is an area of consumer protection involved with the quality of care. There is the other side, which I have not thought about much at this stage, which is the whole notion of consumer power within the system and its ability to evaluate, assess and be accountable.

I do not argue with you that we do not want to use negative terms for this, but it seems there is an element within the social service/health structure where we are talking about very vulnerable groups. The interaction of the state has been there for reasons of protection.

Miss Stephenson: The final role of government is, in fact, the

protection of the public. Some would say that is the only role government should have and it should do that as economically and as efficiently as possible.

Mr. R. F. Johnston: I have heard that said.

Miss Stephenson: The protection of the public is the ultimate job of government. That has to be emphasized, though. I really do not think you are going to get out of it.

The Acting Chairman: I think what you are talking about are definitions of "protection." I am not sure we are talking about--

Mr. Andrewes: I come a little bit from a background of being in one ministry where we spent a good portion of our time regulating the delivery of a service through agencies. The service deliverer was allowed to operate a cartel and the consumer was protected by this agency, which made sure it did not make too much money while it was performing the service.

Miss Stephenson: There is a slight difference between the consumer definition in the area in which you are speaking and the consumer of health or social services, who is primarily a client, a patient or someone subjected to whatever ministrations there are that are necessary to provide him with a greater degree of comfort, a relief of pain or improvement of his current condition.

I think it is the connotation of consumer protection that bothers you in this, when what we are really trying to talk about is the protection of the individual who comes within the orbit of any of these services, in terms of the quality of the care that is delivered and the way it is delivered.

Mr. Andrewes: I guess my greatest fear is that we will set ourselves up as the consumer advocates and that our witnesses will consist of a series of people coming in to tell us their tragic stories of how the system failed them. I hope we can be much more of a constructive tool in improving that service rather than the recipient of all of the horror stories.

Miss Stephenson: I do not think anything we do is going to solve that problem.

Ms. Labelle: The purpose of the criteria is obviously to identify areas for analysis. I do not really know why you chose it, but I would assume the reason you chose that criterion was that the whole commercialization debate often focuses very much on quality differentials.

What we as a group perhaps want to do is to focus on areas where we might be a bit more concerned about quality differentials because the people consuming the services cannot make that distinction for themselves. That is the only reason it was introduced, not because the committee is seen as a watchdog or whatever, but just as a way of ranking priorities.

Dr. Stoddart: I would not mind clarifying that. If I have left the impression either that I thought it was in a negative context or that I thought this should be the theme, that we should run up the flag that this committee is the consumer protector committee, that is not right.

How we eventually suggest that people come and what issues they talk about in phase II and what issues we have a strong interest in as a committee,

how we present that is a separate issue from how we decide what those areas are. I was talking very much in an analytic sense about how we decide what those areas are. I agree, it is a very separate and important task to present this committee's intent to the public and to interests out there in a very careful way.

Mr. Andrewes: A very brief question: Are the data on capital investment available? Have you collected any data on capital investment?

Ms. Fooks: In most cases, when we asked for operating and capital costs--

Mr. Chairman: That was not available.

Interjection.

Mr. Andrewes: It is going to be very difficult for us to talk about where that capital comes from.

Miss Stephenson: You might have that difficulty in the private sector, but why would you have it with the ministries? What am I saying? I am looking at the hospital laboratories, and nobody, but nobody, would be able--and I have to tell you this is a fact--to determine the actual cost of the establishment of the laboratory service at the Toronto General Hospital; absolutely nobody, because you would have to take into account the volunteer contribution of about 500 people who have been actually participating in the development of the quality laboratory plus the tax-free status of the hospital plus a whole lot of other things that have gone on for more than 100 years. You could not possibly determine what that input was.

Mr. R. F. Johnston: You should in a lot of other areas be able to get at least the ministry statistics on the public sector. I am thinking of child care. We should be able to get capital costs and that kind of stuff.

Ms. Fooks: We have whatever the transfer payments are for operating and capital costs. That is a separate issue from the whole industry-wide operating and capital cost, which we do not have.

Mr. R. F. Johnston: Yes, that may be hard to get.

Miss Stephenson: They started off in the private sector and were transferred for a dollar.

Mr. Andrewes: I am sure the Ontario Nursing Home Association transcripts can give you a figure on the sum capital as far as they are concerned. We would have to accept the figure. I do not think we could challenge it or verify it.

Ms. Labelle: We do have figures on building and physical capital costs per square foot in nursing homes, but you are right.

Mr. Ferraro: Why could you not verify those? The ministry asks for tenders on allocations in certain areas, both in the private and nonprofit sectors; why could you not verify those?

Mr. Andrewes: What the ministry asks for in nursing home beds is the tender, the sort of terms and conditions, not so much the--

Mr. Ferraro: Does it not indicate the capital costs of construction?

Mr. Andrewes: The capital cost is really up to the corporation--

Miss Stephenson: If it meets the building code. The space per patient and that sort of thing, the circulation of air, the light, and all sorts of other things are included, but that is all.

Dr. Stoddart: Just to clarify it again, I am not so concerned about getting accurate statistics on how much capital has been sunk in already. I am more concerned that the committee keep in mind that there may be future projections of needed services that could be provided in many different models. Where the capital comes from in the future is certainly an issue--

Miss Stephenson: It is more important than where it came from in the past.

Dr. Stoddart: I encourage the committee to keep in mind the alternative sources when, at the very end of this committee's deliberations, you think about recommendations as to encouraging or discouraging further commercialization.

Mr. Ferraro: With respect, Mr. Chairman, I think Mr. Andrewes's point is very valid. How can you make projections on costs, capital or operating, whatever the case may be, unless you base it on facts which you have to play with?

Mr. R. F. Johnston: The easiest way, for example, is to look at homes for the aged versus the nursing home. In a nursing home, there is no capital cost directly to the public--

Miss Stephenson: To the public.

Mr. R. F. Johnston:--that is within the per diem, but that is supposedly not a direct cost to the government, whereas in building a new home for the aged, we know how much that will cost the municipality, the government and Canada Mortgage and Housing Corp. Your social decision to build the nursing home rather than the home for the aged may be determined by the fact that you need 25,000 new beds and to build that in the public sector would be this expensive, whereas you could operate them under nursing homes without any capital costs.

Miss Stephenson: Capital costs which are amortized in a different kind of way over a longer period of time, that is all.

Mr. R. F. Johnston: That is a debate that we have to have, I agree, but that we do not have to agree on.

Dr. Stoddart: I think where it leads, though, in the evaluative phase, is to trying to get as much leverage as possible on the question of whether performance is integrally linked to ownership and management motivation.

Mr. Chairman: Quality.

Dr. Stoddart: That is the question. It may not be that there is a general answer to that question across all programs or across all sectors. But that's the question. Obviously, if the answer is yes, they are integrally

linked, that has one implication for what one might do in a policy sense. If the answer is no, they are not linked, and performance can be monitored and guaranteed and improved independent of ownership, that has another set of implications for policy. I do not know the answer to that question.

Miss Stephenson: I am listening to this with a déjà vu mindset, because I sat through the corporate concentration hearings of the standing committee on finance and economic affairs and we heard every single trust company, banker, and everybody else who came in say: "You cannot run a company unless you own that company and play a part in that ownership. You cannot do things properly unless you do that."

Mr. Chairman: If I interpreted something Phil was saying when I was out of the room, I gather there is some concern that you are going to have people coming in here trying to justify how they provide quality care service and looking at us as being the watchdog. They have to come forward and justify why they do not have a high enough per diem or whether they are providing ample meals for people in nursing homes and so on. Surely to God we do not want to get into that type of situation. We should be weeding that out.

Miss Stephenson: We are going to hear from the other side. There is not any doubt that we are going to hear from the other side. I am not at all sure you can make a decision about anything unless you hear both sides.

Mr. Andrewes: Richard's committee will be debating that issue probably about the same time.

Mr. Chairman: We have now reached six o'clock. I do not want to cut it off. I have to go open a school, though.

Mr. R. F. Johnston: We should try to set a date.

Mr. Chairman: Debbie has a few thoughts on that.

Clerk of the Committee: No, I have only one. You may not like it, because it is Monday morning.

Mr. Chairman: Sunday afternoon.

Mr. R. F. Johnston: Monday morning.

Dr. Stoddart: This coming Monday?

Mr. Chairman: Yes.

Clerk of the Committee: Either this coming Monday or next. What I have here is a list of all the committees that are sitting next week. That is going to be fairly consistent next week and the week following.

Mr. R. F. Johnston: Monday morning is very bad.

Clerk of the Committee: That is why I said you would not like it.

Mr. Chairman: What about Monday afternoon after routine proceedings?

Clerk of the Committee: Okay. Following RPs on Monday afternoon might be possible, except that the standing committee on social development is sitting at that time and that poses a conflict.

Miss Stephenson: What are you doing?

Mr. R. F. Johnston: Monday afternoon? Education estimates that were postponed today.

Miss Stephenson: I thought you were finished estimates.

Mr. R. F. Johnston: Oh, God, no. February 9 we finish the estimates. It is very awkward for us now to postpone any further.

Clerk of the Committee: I do not think we would get permission to sit if it meant the social development committee had to postpone its estimates.

Mr. Chairman: How about Monday for lunch?

Mr. R. F. Johnston: Is Wednesday out? The social development committee does not Wednesdays.

Mr. Chairman: Wednesday after routine proceedings would be fine, but I chair regs and private bills in the morning.

Mr. R. F. Johnston: Just a second. We do not have a problem with social development. What am I talking about? The reason we had problems with social development last week was because we had health. This is education. We can get substitutions in for education and I can turn the chair over to someone.

Clerk of the Committee: If that is the case, we can go with Monday afternoon or--

Mr. Chairman: You had the problem with Wednesday?

Dr. Stoddart: I have a question. As you know, Roberta is teaching next week out of the country on assignment for McMaster University. I think it would be important for Cathy and I, with her knowledge of the nursing home industry, that she be somehow part of that meeting.

Mr. Chairman: Whereabouts outside of the country is she teaching? We will all go.

Mr. R. F. Johnston: If it sounds good.

Miss Stephenson: Where in Mexico? This is a part of the McMaster program and Roberta is teaching as a result of that. Why are you whispering that it happens to be in Mexico? It could just as easily be in Tromso, Norway, which is bloody cold.

Mr. R. F. Johnston: Why do not we all go to wherever she is going?

Mr. Chairman: Is that a motion?

Mr. R. F. Johnston: Why do not we put it off for a week, until a week Monday? That is what has been suggested.

Clerk of the Committee: All right. If you are going to put it off, what I might do is do a little--

Miss Stephenson: Research.

Clerk of the Committee: --investigating and see what the best times for the following week are. Then I will be in touch with a member of each caucus from the committee and let you know what the best dates are and maybe we can work it out that way.

Mr. R. F. Johnston: It will not be a problem for the social development committee.

Clerk of the Committee: Write that down: the chairman of the social development committee--

Miss Stephenson: Says it will not be a problem.

Mr. Chairman: It is on the record. Thank you very much for your participation, one and all, and have a safe trip home.

The committee adjourned at 6:04 p.m.

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SELECT COMMITTEE ON HEALTH

COMMERCIALIZATION OF HUMAN SERVICES

MONDAY, FEBRUARY 2, 1987

SELECT COMMITTEE ON HEALTH

CHAIRMAN: Callahan, R. V. (Brampton L)

Andrewes, P. W. (Lincoln PC)

Baetz, R. C. (Ottawa West PC)

Caplan, E. (Oriele L)

Cooke, D. S. (Windsor-Riverside NDP)

Hart, C. E. (York East L)

Henderson, D. J. (Humber L)

Johnston, R. F. (Scarborough West NDP)

Reycraft, D. R. (Middlesex L)

Stephenson, B. M. (York Mills PC)

Turner, J. M. (Peterborough PC)

Clerk: Deller, D.

Staff:

Fooks, C., Research Officer, Legislative Research Service

Labelle, R., Lecturer, Department of Clinical Epidemiology and Biostatistics,
McMaster University

Stoddart, Dr. G. L., Associate Professor, Department of Clinical Epidemiology
and Biostatistics, and Associate Member, Department of Economics, McMaster
University

LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON HEALTH

Monday, February 2, 1987

The committee met at 3:30 p.m. in room 228.

COMMERCIALIZATION OF HUMAN SERVICES
(continued)

Mr. Chairman: You have before you a report of the subcommittee. It is fairly self-explanatory. Rather than spend a great deal of time on it, can we simply assume the subcommittee has made a wise decision in terms of what we are going to do here, unless there are some questions or violent objections?

Mr. R. F. Johnston: I am not sure it is all that clear. Would it not be wise just to go through each section?

Mr. Chairman: All right.

Mr. R. F. Johnston: I think we can agree to things. There are a couple of things that are either/or, that are not the same thing, and we might as well make some decisions.

Mr. Chairman: As I said, if there were any violent objections, we would go through it. Hearing a violent objection, we will go through it. Item 1?

Mr. Reycraft: I note that April 17 is Good Friday, so we will back that up one day. I just noticed that this morning.

Mr. R. F. Johnston: I noticed that too.

Mr. Chairman: April 16, then. Is that agreed?

Agreed to.

Mr. Chairman: Item 2?

Mr. R. F. Johnston: It strikes me that the suggestion, which I gather has come from Mr. Andrewes, to parallel what we are doing with the standing committee on social development in the full week before is fine with me. I have no problem with the idea that we advertise for written submissions and then develop our own lists for whichever groups we then choose from the groups below. It is fine with me, if that seems to be more practical.

Mr. Chairman: I could not make the subcommittee meeting this morning. Was the intent that if a person wished to appear, even if a written submission were sent in, he could make the clerk of the committee aware of that and have the right to appear?

Mr. R. F. Johnston: I think the idea behind this approach--and I should let Mr. Andrewes speak for his own suggestion--is that if somebody makes a request to be heard, then the steering committee or whoever can still make the decision as to whether we will add him to our list of invitees. Primarily, we will be advertising only for written submissions, and deputants will actually be selected by pooling lists of groups and organizations that various members feel should come before us. Is that right, Mr. Andrewes?

Mr. Andrewes: Yes. You are doing fine. That is essentially the proposal we made to the social development committee. My biggest fear is that we advertise, try to draw up a schedule, get into these hearings and then, all of a sudden, somebody is sent a three-week-old copy of the Globe and Mail with the advertisement in it. He sees the ad and notifies his interest groups, and at the end of the hearings we have 15 groups that wish to be heard and we are either trying to jam them into the last three days or are not going to give them a fair hearing.

I think it might be a little more orderly if we asked for written briefs and then perhaps selected from those briefs and from a list that members of the committee would submit to the clerk on the recommendation of Dr. Stoddart and others whom we might approach and hear.

Mr. Chairman: My only reason for asking is that I have had communiqués from people, and I had assumed we were going to have public hearings in the usual fashion with a brief read in by the witnesses. If we get to those people, if I can I remember who they were, perhaps we would be able to get the assistance of the committee in allowing those people to appear. I would not want to have misled them.

I notice that Mr. Andrewes has filled in his book for those dates. Those dates are subject to our getting authority to sit. We certainly do not have that yet, have we?

Clerk of the Committee: No; we have to submit a letter to the House leaders requesting those dates.

Mr. Andrewes: It is faith.

Mr. Chairman: Oh, I see.

All right, the next item: "Committee will decide on two or three specific areas of discussion for public hearings." There are four suggestions made.

Clerk of the Committee: May I just put in here that those were only examples that were discussed at the subcommittee meeting. That is not restricting it to those four out of which to choose the two.

Mr. Chairman: Perhaps we can start with the four and see if there are any additions. Are there any additions from any members of committee? These four look pretty good.

Mr. Andrewes: In my absence and your absence, I assume the subcommittee was Mr. Reyecraft and Mr. Johnston.

Mr. Reyecraft: No; Mr. Johnston was not there either.

Clerk of the Committee: Mr. Reyecraft and Mr. Cooke.

Mr. Andrewes: Okay. Are you suggesting that we deal with those four issues? Is that the recommendation of the subcommittee? Or are you suggesting that we deal with two or three of them? What are you suggesting?

Mr. Chairman: The statement says, "Committee will decide on two or three specific areas of discussion."

Mr. Reycraft: Given the amount of time we have, I question our ability to do anything that is really going to be worth while if we take more than two issues. I think we are going to be stretched to the limit if we select two. I would suggest that we take no more than two of those four to hold hearings on during the time we have.

Mr. Chairman: Having heard no additions from the members of the committee, we will assume that we are now going to find out the popularity of these four by putting each one of them to the vote.

Mr. Andrewes: May I suggest that maybe we can reach some consensus without going through the formality of a vote, which may invite us to take recesses to gather up our members, if certain positions could be held forward.

Mr. Chairman: All right.

Mr. Andrewes: I feel very strongly that this committee was initiated, perhaps more than for any other reason, to examine the whole nursing home area. I take full responsibility for the fact that somehow we got off track and got into a whole lot of other areas, because I think it was my motion that took us down that road.

But at the same time, I am very concerned that we examine some of these issues in depth. Perhaps I might suggest that one of those issues be not as narrow as nursing homes but be in the area of health care services for seniors, which would cover nursing homes, homes for the aged, home services for seniors and the provision of those services by both the public and the private sector. That would be my preference as one item.

Mr. Chairman: Any other thoughts in that respect? Did you catch that, Doug?

Mr. Reycraft: No, I am sorry; I did not.

Mr. Chairman: Health care for seniors is the general framework suggested by Mr. Andrewes, as opposed to nursing homes or anything more definitive, and that this is what we would look at.

Mr. Reycraft: My immediate reaction is that it is too broad an issue for us to deal with. We will talk about virtually the whole health care field, will we not, if we are going to look at the role of the private sector in health care for seniors. Is that what you are suggesting, Mr. Andrewes?

1540

Mr. Andrewes: No. I guess what I am suggesting is that we broaden it beyond nursing homes. I do not see how we can talk about nursing homes in isolation without talking about homes for the aged, which is the parallel service of the Ministry of Community and Social Services that carries with it the whole nonprofit guideline.

At the same time, the issue of nursing homes or residential care for elderly people must be weighed against the merits and the cost of providing in-home services so that one can avoid the expansion of that kind of institutional service. I think the issues are vitally tied together and go nicely together, separate and apart from the issues of hospitals, health service organizations and community health centres, which I think are very important as well but whose focus is more on the provision of acute care services and on the prevention and cure of people's ailments.

Ms. Labelle: I have several questions for the committee on the third part of number two. But perhaps further to the point that was just made, one approach might be to examine chronic care facilities or chronic care options for the elderly. That would certainly be in keeping with the terms of reference of the committee, where a comparison between private for-profit and not-for-profit was proposed. That would allow a comparison of nursing homes with homes for the aged and would allow the examination of the alternative home-care option without broadening it so far that you are looking at drug benefit plans for the elderly and those sorts of things.

Should I continue on with my questions?

Mr. Chairman: Mr. Johnston was next. Will Ms. Labelle continue on?

Mr. R. F. Johnston: I think we should probably continue the discussion on this question of the definition of this one area, the expansion of nursing homes into this other area. I gather these were on other matters.

Ms. Labelle: Yes.

Mr. R. F. Johnston: Why do we not continue that?

I have no concern with the notion of trying to do this. I would like to see us try a couple of areas, and if we were to try to do what Mr. Andrewes is talking about, I think that would take up four weeks. It is not so much the problem between nursing homes and homes for the aged, which is not too difficult a thing to do; but adding in chronic care hospitals and various kinds of home support services, and trying to do that in a two-week period, which is half the time we have here, would be virtually impossible. That is the only difficulty I see with it.

Mr. Chairman: Any other comments on Mr. Andrewes's suggestion? We are doing marvellously in coming up with a consensus.

Mr. Reycraft: Because it is an issue that is going to take more time than any of the others that are on the list, I wonder if that issue--nursing homes, homes for the aged, chronic care hospitals and home care--could be something we could set aside for the summer months, noting that the second part of the proposal here is to continue the public hearings in the summer when there might be more time available to us.

There is another advantage in that the amendments to the Nursing Homes Act that are going to go before the standing committee on social development in the first part of the upcoming break will, I expect, be resolved and in place by that time.

Mr. Chairman: Maybe I am wrong, but I understand the social development committee will be hearing witnesses with reference to nursing homes in any event in dealing with that act, will it not?

Mr. Reycraft: It will be dealing specifically with the amendments.

Mr. Chairman: But I am sure it will be receiving witnesses.

Mr. Reycraft: That is my understanding.

Mr. Chairman: It may well be that Mr. Reycraft's suggestion makes sense and that we will have the benefit of those--I suppose we would have them

anyway because we are meeting in the latter part of March and the early part of April.

Mr. Andrewes: My difficulty with that is that the amendments are quite specific. They do not deal with the ideological arguments of commercialization versus nonprofit. They deal specifically with the operation of nursing homes, the opening up of the process of adjudicating expenses within that operation and providing for some type of scrutiny by residents' committees of the profitability of a particular nursing home. It moves somewhat off our philosophy, which, in my view, is to try to determine whether the level of health care service is affected by a profit motive.

Mr. R. F. Johnston: I agree with Mr. Andrewes that, although there will be some information coming out of that process that might be of interest to us, the questions being asked are not the same, but I think there is something to what Mr. Reycraft is saying.

I am beginning to think that maybe dealing with this whole question of health care services or long-term care services to the elderly as a holistic package might be something that is better done with six or seven weeks available to us instead of trying to squeeze it into a two-week portion of this period we have before us or in terms of making this the only thing we deal with at this stage. I would like to see us go in a couple of areas, if possible. Is that a problem for you? I gather you made the argument initially that we are sort of the *raison d'être* of the committee in the first place, and therefore maybe it is what we should be dealing with first.

Mr. Andrewes: I do not have any strong feelings about the order. I guess my concern is dealing with nursing homes in isolation from the other services. If there is some strong feeling that we should postpone that discussion until the summer, I do not have any particular objection to that.

Mr. Chairman: Can I assume from all of that that we have gone past the nursing home item and we are now on hospitals?

Mr. R. F. Johnston: Except that do we have a consensus on trying to do it holistically like that? I like that notion myself, that we deal with chronic care hospitals, the homes for the aged, nursing homes and home care. I do not know where we are going to cut it off in terms of other home support services, but that is--

Mr. Reycraft: And chronic care hospitals as well, or did you include them?

Mr. R. F. Johnston: I think I had that at the beginning.

Mr. Andrewes: I wanted to ask Roberta: When you talked about chronic care, were you speaking about small-c chronic care?

Ms. Labelle: Generic chronic care?

Mr. Andrewes: Generic chronic care.

Ms. Labelle: Yes. I suppose what I was trying to get at was that there are alternative ways of delivering care to the elderly. Some are delivered at home, some in the hospital, some by the for-profit sector and some by the not-for-profit sector. It seems to me that what we had discussed earlier on was an evaluation, a comparison of the types of care.

I think your point is entirely valid. It is tough to say anything about nursing homes because it begs the question, compared to what? It might come out of part of the analysis, for example, that some of the patients, say, in a nursing home facility, are misplaced. In that case, the logical next step is to examine what the alternatives are. If you look at the package of long-term chronic care for the elderly, you will encompass in that a number of services and types of delivering those. That would be in keeping with the spirit at least of the committee and its original terms of reference.

Mr. Chairman: You were asking Mr. Reycraft if we were going to put anything on the record that this is what we were going to do. Can we not just leave that? The clerk is not going to make--

Interjection.

Mr. Chairman: Okay, we will show it as a consensus and we will move on, then, to the next item. I gather the next items will be discussed, or certainly the hospitals, the health service organizations and community health centres will be discussed with the elderly component removed from them in the light of what we have just decided.

Mr. Andrewes: I assume so.

Mr. Chairman: Then we have three left. We can take either three or two out of those three.

Clerk of the Committee: Two, the majority agrees.

Mr. Chairman: All right. Which two do you wish out of those?

1550

Dr. Stoddart: May I ask a question at this point? How were these four arrived at from the large set of possibles? I would like to know, because from my point of view it makes a difference in how much we do in future research. To what extent was the documentation that Research Innovations prepared for you and that Cathy Fooks prepared for you useful in coming to that conclusion?

Mr. Chairman: You are on, Mr. Reycraft.

Mr. Reycraft: The one of those that interests me most is hospitals, at this stage, or the one that has not been mentioned by a number of others.

Mr. R. F. Johnston: I think it is fair to say--and I was not at the meeting, but someone got back to me about it--if you look at these, in both the work that Cathy Fooks did and also the other longitudinal kind of analysis, or however you want to look at it, these are all areas that were highlighted for us and picked out as areas that should be of some concern.

Nursing homes, self-evidently, because of the information, I would rather go into. They spent an awful lot of time giving us information about why there are trends in hospitals that we should maybe look at. Whether we accept it or not, it is undeniable. We have received information in these packages, not so much out of Ms. Fooks's package as in the other group's.

Child care was pinpointed for us, in the sense of the proportion, and we know there is a large amount of both private and public dollars going in there

and there may be changes coming up there. It would be an interesting area to highlight.

I do not know how the health service organization/community health centre thing came up, but I think it was because of the whole notion of doctors' services, which is something we did not get into in the accumulation of data. I gather that is where that one came from, was it not?

Mr. Reyecraft: It was put forward by Mr. Cooke without a great deal of explanation at the meeting of the steering committee this morning.

Mr. R. F. Johnston: That is the only one that does not come out of the data, I think.

Dr. Stoddart: The reason I asked is that the last one--certainly nursing homes and day care data were highlighted in these documents, partly because there is a large proportion of this sector provided on a for-profit basis or because there are changes going on in the sector.

It was not apparent to me that any of the data presented would have flagged HSOs and CHCs for a committee on commercialization, although it is obviously a very important issue in the health care system--alternative delivery modalities within the public plan. That is why I was asking about them.

Mr. R. F. Johnston: Mr. Andrewes, you have talked with Mr. Cooke about it a bit, have you not?

Mr. Andrewes: Really not in this context. I respect what Mr. Reyecraft is saying, because it kind of looms up at you. It was not an attempt to put together a lot of data and research in terms of HSOs and CHCs.

I am a bit perplexed at this point to see how you make the comparisons, other than looking at it as an alternative to the current system of public hospitals. It is whether or not, within the public sector, you have an alternative to the current system. I do not know that there is any attempt to privatize HSOs or CHCs. Perhaps more appropriately, one would want to look at the whole principle of health care delivered through a capitation system versus a fee-for-service system.

Mr. Reyecraft: If I can be helpful, I think what Mr. Cooke was suggesting in the meeting of the steering committee is that we do some comparison between models such as the HSOs and the delivery of health care service on a fee-for-service basis from physicians' offices.

Mr. Chairman: I have to say, if I had been at the subcommittee, those are the three items I would have raised, but having heard now from Dr. Stoddart, drawing to our attention the fact that if the data that were accumulated really did not have reference to hospitals or HSOs or CHCs--

Dr. Stoddart: I guess what I am thinking about here is, if this is indeed a committee on commercialization, then Mr. Andrewes's point of a few moments ago is quite relevant. He said what we are really trying to get at is, in some general sense, the effect of commercialization, of provision of services on a for-profit basis, on the quality or the level, the accessibility or whatever, but on the performance and (inaudible) alternative models.

To that extent, what I always saw the committee doing was focusing on

some specific examples, some areas, not because it wanted to sort out the nursing home or day care industries, but more because it wanted to use those as examples to arrive at some guidelines or some principles to suggest to the province the level of for-profit activity in health and what its impact tends to be, so that lessons might be drawn for other sectors in the future or for other sectors now.

Somehow, the committee's contribution would be not just to help with the provision of specific services, current problems, but also to try to set some kind of discussion or put forward a package of proposals about how the future might evolve in the health care system, under what circumstances commercial activity would be helpful and under what circumstances it looked like it would not be helpful.

If that is the case and that is how these specific areas are being chosen, on the issue of commercialization, I do not see that there are many lessons to be learned one way or the other from HSOs and CHCs. What is to be learned, as we have said, is whether more cost-effective care can be provided within the public health system if that money is fed out on a capitation basis, salary basis or fee-for-service basis.

Short of somehow defining the fee-for-service system as a profit-making system and the other systems as a nonprofit-making system, I just do not see how you slide it in under commercialization, although it is a very important issue in the health care system.

In terms of restructuring Ontario's health care system, it may be the most important issue about delivering models within a public plan. All I am saying is, in terms of commercialization, I find it is hard to fit it that way, if the goal of the committee is to think about guidelines for the future provision of services of all types.

Mr. R. F. Johnston: Why do we not leave the discussion about whether we deal with that whole question for later? I agree with everything Dr. Stoddart said except that he should always add "and social services" after he says "health."

Dr. Stoddart: Sorry.

Mr. R. F. Johnston: I just keep reminding the health addicts around here of that.

Dr. Stoddart: It is broad; I always interpret it that way.

Mr. R. F. Johnston: I am very interested in us doing a child care analysis. We seem to be left this time to stick only with the short list of dealing with the question in the hospital sector of commercialization and privatization in that sector at this stage. Unless there are other things you want to do, perhaps our discussion could come around to how we would deal with those things and other comments like those that Mr. Andrewes made around nursing homes that we need to think about in terms of our definition of what we are talking about around hospitals.

I think child care is a pretty self-evident area by itself but around hospitals, the limitations and the extent that we want to look at that area, is it just the question of nutritional and laundry services or is it more than that? It is mostly stats we received on that.

Can we perhaps get out of the way that day care will be one of them and then try to decide--

Clerk of the Committee: Can I get some clarification? Are we going to call it day care or children's services?

Mr. R. F. Johnston: I prefer to call it child care or day care than children's services, because we would have to deal with too many other things.

Clerk of the Committee: That was what I wanted to know; whether you wanted to broaden it or restrict it to day care.

Mr. Chairman: I would like to keep it in mind that with seniors we are going to use services for seniors. Maybe we could use services for children?

Mr. R. F. Johnston: No. It is far too broad at this stage. I think we have a specific sector of that area now in child care that we should look at, but there are other areas I do not think really warrant us looking at at this stage; children's boarding homes, which is the only other statistically interesting thing that we got out of the data, are so different from the question of child care that I just do not think you could put the two together.

Mr. Chairman: Have we a consensus that child care will be one of them? So we need the second one.

1600

Mr. Andrewes: I do not have any long dissertation to make with respect to child care since my kids are too old.

Mr. Chairman: You only look after one generation at a time, do you?

Mr. Andrewes: With respect to Mr. Johnston's comments about hospitals, I have a great deal of difficulty seeing how we could constructively spend two weeks hearing from people about whether or not they contract out services in hospitals, such as food services, laundry and things like this. We have got fairly extensive data on that and I do not know where there is a whole lot of discussion to be had once you look at the data.

You can get into the ideology and the labour arguments and these kind of things but I am not sure that is going to serve the purposes of our report very well.

With child care there is a contrast. You can look at the commercial sector and you can look at the nonprofit sector. I am not sure there is a contrast to be seen in the hospitals, so we are faced with finding one more area in which we want to focus our attention. Can I come back to my argument about seniors?

Mr. Chairman: Let us hear it now as opposed to the summer. I thought we had a consensus on the summer, but it appears we are coming back to it again.

Mr. R. F. Johnston: The points Mr. Andrewes is making are pretty valid points as far as I can see. That is basically why I was asking the question. Besides things like laundry services and nutritional services, are there any indicators there of other matters within the hospital sector that we

should be looking at in terms of trends or on commercialization or privatization? There are also the labs.

Mr. Turner: I guess that opens up the whole question of hospital operations. How far do you want to go? Laundries and food services are pretty well a fait accompli, are they not, in most hospitals?

Mr. R. F. Johnston: They seem pretty high on both sides, I guess. However, there are all the other questions. We have pharmacies working out of hospitals and special dispensations compared with other pharmacies. We have special labs. There are a range of other things that fall within the hospitals' mandate.

Mr. Turner: Then there is the basic administration of the hospital itself.

Mr. R. F. Johnston: Which is now happening as well.

Mr. Chairman: Can I make a suggestion as a sawoff? Day care itself is probably going to take a significant amount of time. If we did look at the laboratories and the pharmacy issue, and even the question of the contracting out of the laundry, the food and so on, and use that as a filler, I think the time we have is probably just going to cover those two. I may be wrong.

If we get to the stage where we would perhaps like to expand that along the lines of what Dr. Stoddart might be suggesting, or Mr. Andrewes's statements, maybe we can bring that into the summer, before or after the seniors, because there will be connections, quite obviously, between the seniors, the health service organizations and the community health centres. It might be something we want to do during that period of time.

Can I suggest that as a combination so we can close this off?

Mr. Turner: I put the question again: is there enough to discuss with laundries and food services? Might that not pretty well be established within the context of the hospitals?

Ms. Labelle: I am just a little concerned that we might be crossing boundaries here. Certainly, the pharmaceutical point of view was analysed in a separate section on pharmaceuticals; similarly with labs. It was not seen as a hospital issue, it was seen as a lab issue. The committee might want to make a decision as to whether or not it is interested in pursuing the lab issue.

If this is a process of trimming down the set of things you are going to look at, perhaps I could remind you of a conversation we had earlier, when this all began. It was about the idea of contracting out the management services and laundry services and that sort of thing. Although I think everybody recognized it was very important, and certainly laundry is a fundamental part of providing hospital care, it typically is not seen as either a health or social service matter. The committee had thought it might be better to concentrate on actual services provided to patients that fall into the realm of health or social services and that laundry, although it is important, might be excluded from that set.

Mr. R. F. Johnston: How about the matter of contracting out? I had forgotten about that. In terms of the provision of health care through a hospital, surely that becomes a major issue: whether we keep the public board notion or whether we go to the American multinational format in terms of

running it. Did we decide that was one of the things we wanted to lump in with laundry?

Ms. Labelle: No. At the time we thought it might be a contender in so far as different management styles might have an effect on patient care and that anything that could be linked directly to the quality of patient care was open for consideration. It was less clear how laundry affected the quality of patient care. At the time, we had left it in a feasible set while we had ruled out meals, maintenance, laundry and those types of things. One option might be to further reduce the category "hospital" to "private versus public management."

Mr. Reycraft: It is certainly the management area that I am more interested in examining. We have heard at length already in committee about the Hawkesbury example. It might be worthwhile to look at the whole system of hospital care to explore other opportunities to apply the same principles that were applied there. It was not my intent to look at things such as laundry care and food services in hospitals. I quite agree it is not going to be very helpful to the overall health care scene to examine those things.

Dr. Stoddart: I have another question about what is possible and what is not possible. You can probably tell me right away. Is it possible for the committee to say: "The committee has examined these data; the committee has done its inventory on the extent of commercialization in the province; the committee is quite concerned about a couple of areas on the basis of criteria X, Y and Z and the committee encourages briefs, especially in these areas on which it will focus the majority of its time? However, the committee recognizes that there might be other areas of concern to citizens of the province and briefs in other areas are not excluded?"

Then, at the end of the hearings in the summer save some time--it could be announced in advance or worded carefully that it was a limited amount of time--to look at other areas in which commercialization may have significance or there may be lessons to be learned, so that the committee is not excluding people. I do not know whether the committee can do that; that is my real question. Can you say to someone, "You cannot come before us," or "You cannot submit a brief on this topic," given that we have a select committee on commercialization?

Mr. R. F. Johnston: Yes.

Dr. Stoddart: It might be an easier way to let someone submit something, knowing there may be no time for those topics, but that they are not excluded from the beginning, without mentioning management contracts or labs or anything by name, just leaving a residual pool after the two identified areas. Is that just leaving it too open?

1610

Mr. R. F. Johnston: I am not sure exactly where we are going now. We have decided we are going to do child care. We are going to do the chronic care needs of the elderly in the summer. But I am not clear--are those the two issues we have decided upon that you were going to raise?

Dr. Stoddart: About the two that I heard, I thought there was a consensus. What I heard on the third one was that people had different suggestions and were trying to define them. I was merely suggesting that maybe you could leave a residual pool undefined and say, "We will consider in a

limited amount of time such other examples as may be of concern to the citizens in Ontario."

Mr. R. F. Johnston: I think we are going to have to deal with those things anyway. They will come in no matter how finely we prescribe what we put into our ad. The ads have a very specific kind of formula to them, unfortunately.

Clerk of the Committee: To add to that, in fact they have already come in. My office is receiving briefs right now in areas the committee has not even touched upon, which I am putting into a binder along with every other brief I have received. Those things do come in, whether we ask for them or not.

Mr. R. F. Johnston: I do not think that coming in is so much of a problem. I think the inevitability of our having to make decisions on that kind of limitation later on will come clear to us as well. What I am not clear about is whether, in the period we have set aside for ourselves, we are planning to deal with anything other than the child care issue under the Ministry of Community and Social Services side of things. I was presuming we would probably try to do one of each at this stage. Is there anything under Health you would like to do?

Mr. Chairman: Mr. Reycraft has put forward a question on Mr. Cooke's reasons for suggesting health service organizations and community health centres.

Mr. Reycraft: Those were Mr. Cooke's reasons.

Mr. R. F. Johnston: We agreed to set those aside. Now we are trying to decide whether there is anything within the hospital sector that we want to look at. I guess the real question is how much--perhaps we should say we are going to look at the management question of hospitals. There are not that many examples in Ontario at the moment that we can turn to. Travel is the next question below that. If we want to look at other models in that area, we could reserve the last few days or something like that for coming back to deal with that issue. It probably would not need much more than that in the way of public submissions, and maybe our going out to Hawkesbury and--is Etobicoke, the Lakeshore, the other area?

Mr. Chairman: Sault Ste. Marie; is there one in the Sault?

Clerk of the Committee: No; Queensway.

Mr. R. F. Johnston: We could reserve time near the end of this period for dealing with the question of private or public management of hospitals. We could leave that to the last week and have three weeks for child care. Is that what we are talking about?

Mr. Reycraft: It sounds reasonable.

Mr. Baetz: Can you enlighten me? If we get into the field of day care, what are we talking about? Is it the whole field of day care services? Is it social services for the children?

Mr. R. F. Johnston: I presume we would be dealing with what was under the old Day Nurseries Act and is now under that section of the Child and Family Services Act, which would be the pretty broad range of what is available in private home day care, commercial day care, publicly run day care

and not-for-profit group day care. We may want to get into some of the more specialized areas such as mentally retarded spaces and that kind of thing, but I was presuming it would be in that broad mix we have had the stats on.

Mr. Baetz: I was just wondering, and again I need enlightenment here more than providing an answer, if we are going to get into this, especially in the light of the very limited time, is this not pretty far afield from where we had gone into this subject to begin with when we were talking about--at least I thought we were largely interested in public or private nursing homes and so on and relating it to the health field.

Mr. Chairman: You may have missed the suggestion that the nursing homes issue be put off until the summer.

Mr. Baetz: It will be in the summer.

Mr. Chairman: Yes.

Mr. R. F. Johnston: One of our problems from the beginning on the definition of what this committee is has been that it is always called the select committee on health, wherever you go.

Mr. Baetz: Yes, I get carried away by that word.

Mr. R. F. Johnston: However, if you look at our mandate, our mandate is very clearly to look at commercialization and privatization of health and social services. That is why I would like to see a mix of the two in the first run at it.

The question of the commercialization and privatization within child care is interesting because, according to the stats we have received, there is a very interesting balance between the two at the moment. There also seem to be some developing policies, federally and provincially, that may have an impact on how that goes. It is an interesting time to look at that issue as one of the range of things we do. That is why it is very much within the initial mandate even though we keep calling ourselves the select committee on health.

Mr. Baetz: There is no doubt that at the moment it is a live public issue. I guess I must have missed a meeting here, but I wonder whether this is an issue this committee should be getting into at this point. I guess the decision was made some time ago that you would.

Mr. R. F. Johnston: Right.

Mr. Chairman: We have had a fairly lengthy discussion of this. I do not want to cut it off because we need very definitive terms for the clerk to be able to garner the appropriate people before us, but it seems to me that with the day care issue, plus looking into the question of laboratories, pharmacies and perhaps on a very minimal basis the other contracting services--I do not want to get into laundry or food provision--that may be enough to occupy you. We all know that with three weeks, we usually wind up sitting three days of the week. We are really looking at about nine days.

Mr. R. F. Johnston: I am a little worried that we are getting away from where we seem to be going in the end. I would like to make a recommendation and see if it flies at this point: That we do three weeks of hearings or schedule up to three weeks of hearings on child care and that we

reserve the last week that is available here to deal with the question of public or private management of hospitals. Will that fly or will it not? Is that unreasonable? We decided to keep the pharmacies and labs separately because we might deal with them as labs or--did we not?

Mr. Baetz: Then you are suggesting that in the summer we deal with the nursing homes, public or private.

Mr. R. F. Johnston: Exactly.

Mr. Baetz: I see.

Mr. Turner: When do we get back into the area of seniors' health care again?

Mr. R. F. Johnston: In the summer.

Mr. Turner: That will bring the hospitals back in.

Mr. R. F. Johnston: Possibly, although I gather that we are going to try to limit ourselves to the use of chronic care if we are talking about hospitals. It will be chronic care spaces and that kind of thing at that stage and the public versus private--which is the best in terms of quality of care and which is the most appropriate and that sort of thing. We would like to do that, according to Mr. Andrewes's suggestion with which I agree, as part of a continuum of care that is out there for chronic care for the elderly.

Mr. Chairman: Could I ask the clerk to read back what you have suggested because it went right by me? What did he say?

Clerk of the Committee: That the committee consider the issue of child care in the first three weeks of the sitting and that the last week be reserved for consideration of the public and private management of hospitals.

Mr. Chairman: My understanding was that we had only three weeks.

Clerk of the Committee: This is four.

Mr. Chairman: We have February 23--

Mr. Reycraft: The last one is a four-day week.

Mr. Chairman: All right. You have heard that. Is there any discussion on that?

Mr. Andrewes: I will not speak against it. I want only to be clear that I really do have some concerns, and they relate to some of the things my colleague Mr. Baetz alluded to. Here we have the heading of this prepared just fresh off the press this afternoon--select committee on health. I quite agree that it is well within the mandate of this committee that we look at day care and social services, but the public's perception of the select committee on health is going to be that the first issue on its agenda is day care. I have some concern that the credibility of this committee in its future role will be somewhat diminished if we proceed in that direction. Having gone through the agony of this discussion, trying to isolate what in fact we do for those four weeks, I expect that we reached a reasonable compromise.

1620

Mr. Baetz: Can I make a comment or reinforce my earlier comment on this? I thought initially it was the whole issue of the private or for-profit or not-for-profit aegis or sponsorship of the nursing homes that got us into this whole deal. That was sort of our first priority; we were going to take a look at that. Sure, it was not going to be the exclusive subject of interest to us, but that was the starting point. If we are going to do all that next summer, that is another thing, whatever next summer brings. I know the whole question of public or private or not-for-profit administration of day care is the big issue right now. It is, but how much more can we add to that public debate? My God, you know--

Mr. R. F. Johnston: It would be limited if you were not here, Reuben, but with you here I have a feeling it will be--

Mr. Chairman: All right.

Mr. R. F. Johnston: May I just read to you, Mr. Chairman, the opening sentence of our terms of reference?

Mr. Baetz: That is a good place to start.

Mr. R. F. Johnston: "The select committee on health"--which does need to be renamed--"to consider the role of the commercial, for-profit sector of health and social services and to recommend what role the commercial, for-profit sector should play in the provision of human services in Ontario...."

I think we have a problem with the title. I agree with that and the comments about--

Mr. Turner: Select committee on human services.

Mr. R. F. Johnston: Select committee on human services--renaming it or suggesting it be renamed so there is less confusion would be a useful thing, but it is definitely within our mandate. That is why we collected or tried to collect all that information from the Ministry of Community and Social Services.

Mr. Baetz: At least a change in title would save the chairman daily explanation of why he is into that field if it is a select committee on health.

Mr. R. F. Johnston: I do not know whether we can move a change in our name. Are we allowed to do that?

Clerk of the Committee: You can write a letter to the House leaders.

Mr. R. F. Johnston: We will do that. Mr. Turner, why do you not write a letter to the House leaders on that suggestion that we be called the select committee on human services or something like that, indicating--

Mr. Turner: Sending a clear signal to the public, if not to members of this committee.

Mr. Andrewes: Change the letterhead.

Mr. Chairman: You will have all the animal activists in here.

Mr. Turner: So what?

Mr. Reycraft: You mean the animal rights activists.

Interjections.

Mr. Chairman: We have had a fairly significant discussion about this. Is it clear enough?

Clerk of the Committee: Is it agreed?

Mr. R. F. Johnston: Yes, three and one.

Clerk of the Committee: Three weeks on child care and one week on public and private management of hospitals.

Mr. R. F. Johnston: Yes, and leave to sit in the summer on the--

Mr. Chairman: It might be that we may spill over. That may become--never mind.

Clerk of the Committee: I need more clarification now that you have done that.

Mr. Chairman: All right.

Clerk of the Committee: Do we want two advertisements? Do we want one advertisement that has both in it with both dates?

Mr. R. F. Johnston: Yes.

Clerk of the Committee: One?

Mr. R. F. Johnston: That is my suggestion because the hospital people might want to make presentations to us. Time to do that in advance makes it easier for us to choose whom we are going to schedule for that last week. Why not do that and it saves money bringing them together?

Clerk of the Committee: Okay. The only other thing is I will need a deadline date from you for the submissions.

Mr. R. F. Johnston: Go, Phil.

Mr. Andrewes: My suggestion would be that we might want to look at asking permission of the House leaders to get leave to sit in the summer so that we may incorporate the total package in the advertisement and invite submissions now on the seniors.

Mr. R. F. Johnston: That is good. I think that would be great if it is not too confusing in terms of the ad; in other words, talking about exactly what it is we are going to do, our full schedule. The trouble is we cannot tell dates for the summer.

Mr. Chairman: Is it not a little presumptuous to set our sights on

the summer at this point? There is still snow on the ground. I think in fairness to the people--

Mr. Turner: There may be other great events--

Mr. Chairman: That is right. There may be other great events that will unfold. I was not thinking of that at all. All I was going to say was that it is certainly a significant enough issue that we do not want to put it in yesterday's newspaper and then come out in the summer and have nobody here.

Mr. Andrewes: My principal reason for suggesting that was to get over this sense I have that we are moving off into another field first before we deal with the mandate or the product that spawned the committee's birth in the first place.

Mr. R. F. Johnston: I think what Mr. Andrewes was suggesting was that we ask permission of the House leaders to do this. All right, Mr. Andrewes?

Mr. Andrewes: Yes.

Mr. R. F. Johnston: I think that is a good notion. They may say they think it is presumptuous, but why do we not suggest to them that we think it should be put in that context because of the reasons of confusion, to give people lots of lead time to get things back to us, etc. I hear a consensus.

Mr. Reycraft: Agreed.

Clerk of the Committee: Before you put an ad in, you want to first find out whether you have authority for the summer so that you can include that in the ad.

Mr. Chairman: If we do get that permission, what is the date for the deadline on submissions?

Mr. R. F. Johnston: Since we are not primarily choosing people from the submissions, why can it not be fairly late, such as before we come back and start, some time during the reading break or the week before? Can the deadline be that late? Then we might select a few of the interesting ones from the submissions but we primarily would have scheduled ourselves for the first couple of weeks anyhow from our own lists.

Mr. Chairman: Agreed.

Dr. Stoddart: I have a question again that bears upon research that might go on for this phase 2. The nursing home area is a pretty controversial area and such evidence as there is is hotly debated. It would be extremely important at the outset for the committee to indicate that it is going to go into this area of nursing homes or chronic care for the elderly or whatever the envelope label is. I suspect that if you want to have any adjudication of competing claims on the basis of evidence, you are going to have to set a date for those submissions that is perhaps a little earlier than the middle of the summer, maybe May or something, to allow some time to work to whoever we can get to adjudicate some of these claims.

My understanding is that even though it is not conclusive or not as much

as we would like, there is a lot more evidence around on nursing homes than on some of these other areas, so we may need more lead time.

Mr. R. F. Johnston: It has been done before and it would not be a problem. I think it would add strength to Mr. Andrewes's request if we suggest that we would like the deadline for submissions to be mid-May or the end of May probably. Then we could ask for leave to sit once or twice to look at that before we set our summer schedule out. I think it is a good idea. What do you think?

Mr. Reycraft: Agreed.

Mr. R. F. Johnston: Travelling.

Mr. Chairman: Yes, travelling.

Mr. Andrewes: I agree but I have one more issue to raise.

Mr. Chairman: Yes.

Mr. Andrewes: The interim report.

Mr. Chairman: We are going to deal with that right after this.

Mr. R. F. Johnston: It is okay with me. I am presuming we will not want to travel an awful lot at this stage and putting three centres down as something that would be the maximum rather than the minimum is fine with me. Frankly, I would be just as happy to stay here and bring people to us but we may feel that we have to go to three areas. If we do, it should be no more than that.

Mr. Turner: I am not trying to extend the travelling, but you are suggesting a choice between North Bay or Thunder Bay.

Mr. R. F. Johnston: London should be taken out of there and it should be Ottawa, Thunder Bay and one northeastern one.

Mr. Turner: That is what I was going to suggest.

Mr. R. F. Johnston: Not London. They can drive from London and from Windsor.

Mr. Chairman: So Ottawa, Thunder Bay and what--

Mr. Reycraft: Mr. Cooke might not be happy about that; he had Windsor in at one time.

Mr. R. F. Johnston: He is not here.

Mr. Chairman: Ottawa, Thunder Bay and where else?

Mr. Turner: Sault Ste. Marie or Sudbury.

Mr. R. F. Johnston: Sault Ste. Marie or Sudbury, one or the other. Probably Sudbury would be easier for people to get down from Timmins and other places.

Clerk of the Committee: Ottawa, Sudbury, Thunder Bay: Do you want

those places left out of the ad, and then we will just see what kind of response we get from areas?

1630

Mr. R. F. Johnston: Yes. If we find out, as we did with one of the other committees we had recently, that there are only two groups wanting to come to see us from the northeast or whatever, then we will invite them down here and not bother doing the trip.

Mr. Chairman: Is there a consensus on item 3 that if we are to travel, it will be Ottawa, Thunder Bay and Sudbury?

Agreed to.

Mr. Chairman: All right. Is that all you need, Debbie?

Clerk of the Committee: Yes.

Mr. Chairman: Perhaps we can get down to questioning of the interim report in the remaining time.

Clerk of the Committee: I have just one more thing. Can I call the subcommittee together for approval of the ad?

Mr. Chairman: Yes; right.

Mr. R. F. Johnston: Yes.

Mr. Chairman: Go with what the subcommittee says is appropriate.

Mr. R. F. Johnston: I hope you have as much luck with your turnout.

Mr. Reyecraft: It may require written notice to the chairman; that is all.

Mr. Chairman: That is one of my own members. That is the sharpest cut of all.

Okay, interim report.

Interjection: Who has suggestions?

Mr. Chairman: Where is it? Have you got it written?

Ms. Fooks: No; I have not had direction from the committee yet.

Mr. Chairman: All right. The ball is in our court--your court, I should say. I am just the chairman.

Mr. Andrewes: May I suggest at the outset that the interim report contain a statement relative to our past activities--that is, the collection of the data and so on--that the data be attached as a compendium and that a subsequent statement state that the committee, after lengthy discussion and without acrimony, agreed it must narrow its focus and therefore has agreed to an agenda, the agenda the clerk has just given us? I would include in that, of course, the summer agenda. All that will probably take three or four good pages of well-written prose--

Mr. Chairman: Triple-spaced.

Mr. Andrewes: --which I am sure Cathy is going to turn out for us. I think that at the outset we need to say what we are doing and why we are doing it. That is the big concern.

Mr. R. F. Johnston: I agree with Mr. Andrewes on this. The other thing our second statement should include is the matter Greg raised: that is, that the things we are not dealing with at the moment are not necessarily things we are not going to look at; they are not the first things we are going to look at. Such things as comparing children's boarding homes with children's mental health centres and the ways those are administered--one being entirely public and the other being that interesting mix--would be of interest to me at another time. That is something we may look at, and we may actually get briefs about it over the next while. We should add something talking about, "but not limited to, the foregoing" or "aforementioned" to it. I do not think we need much more than that as an interim report.

Ms. Fooks: May I ask you a question? In your compendium of the data, I presume you just want the data presented as they have been presented to you. But in the interim report, do you want some text on the data for the areas you are going to look at in the public hearings: child care and hospital management? Otherwise, there is going to be just a bunch of statistics that people are going to have to plough through.

Mr. R. F. Johnston: There are two ways of doing it. One is to do it as just a couple of paragraphs, and the other is to include a summary of the data involved with a sort of synopsis at the end that says, "We have now decided to move into these areas because of the high concentrations and the whole question of what the future of management in hospital care is," or whatever we want to use for that. I think some sort of summary is probably a good idea to have included.

Ms. Fooks: Of all the data or just of the child care and--

Mr. R. F. Johnston: I would think there may need to be more of the data than just the ones we are choosing right away. It has to be a summary of the report.

Mr. Reyecraft: It was my expectation that we would get some comment on the trends that were obvious in each of the areas we looked at, but not that it need be particularly lengthy.

Ms. Fooks: I guess I had in my mind two ways of doing this: include the data as a compendium with the report, which I guess I had not thought would be much work; and then, once the committee had decided on the areas it wanted to look at for public hearings, have a discussion within the report part of the interim report of those two areas. But the other way of doing it is then to have the interim report be a summary of all the data and at the end say, "Now we are going to look at A and B."

Mr. R. F. Johnston: That is more work.

Ms. Fooks: Yes.

Mr. Reyecraft: B.

Ms. Fooks: Is that what you want?

Mr. Reycraft: I think so.

Ms. Fooks: Okay, so you want a summary of the data you have had presented to you thus far; and at the end of that, the committee is going to look at child care and hospital management contracts.

Mr. R. F. Johnston: In the summer.

Ms. Fooks: So there would not need to be any further discussion of those two areas, then. Have I got that right?

Mr. Andrewes: In the interim report.

Ms. Fooks: Yes.

Mr. Andrewes: Yes.

Ms. Fooks: Okay. My second question was, does the committee wish to include in the interim report any questions or issues it wants addressed in the public hearings in relation to the areas it has picked or do you want to leave that wide open? At one point we had talked about including in the interim report some kind of loose framework for the public hearings so that we would not be all over the map. If you want to do that, then you have to tell me what they are.

Mr. R. F. Johnston: I am not sure we need it now for these, do we? I am just trying to think about it. Talking strictly here in terms of commercialization and privatization of child care, I am not sure what the range is going to be there. We are dealing straight with hospital management. That should be pretty self-limiting, should it not, unlike, for instance, the difficulties we may have when we try to deal with the whole services package.

Ms. Labelle: I think what would be helpful, perhaps, for Cathy and for hearings is that if you do want to direct evidence and specific questions, some of those might come forth. So, for example, in the area of hospital management, if you are concerned with quality implications, you would highlight that as an area of interest. If you are somewhat interested in cost implications and what effect they have had, or in access implications, those sorts of things--or in equity capital, which just came to me--and if you highlight those early on, then it will serve, perhaps, to direct groups right at the questions of interest instead of having them come from all different folks in all different aspects of the category that was identified.

Mr. R. F. Johnston: It is going to be hard to do that with the ads.

Ms. Labelle: Oh, no. This is part of the interim report.

Mr. R. F. Johnston: I see.

Ms. Labelle: Should she highlight in her draft the areas of concern or consideration for what we have labelled phase II?

Ms. Fooks: This is assuming that people who are coming to present to the committee will be looking at the interim report.

Mr. R. F. Johnston: I would be interested in seeing us try to do that. It is going to mean meetings between you and the steering committee, clearly, to have that develop.

Mr. Baetz: You should also indicate that we would be interested in going beyond just the straight cost-benefit analysis and so forth--

Mr. R. F. Johnston: Into quality.

Mr. Baetz: --and get into the philosophical questions of a pluralistic society, choice and the whole thing. I suppose people coming will get us into that anyway, but I think something ought to appear that we are interested in that.

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Mr. Reycraft: Should we be concerned that if we do attempt to identify specific questions and specific areas, we might restrict the hearings or the focus of the study--our work? Are groups that want to make presentations going to look at those and restrict their comments or observations or recommendations to only the things that are identified? If that happens, then is there not a danger we will miss something that might be more important?

Mr. Chairman: Why are we narrowing the terms of reference, in a sense, by being more specific? Why not just reprint the terms of reference? That way, we would get briefs from any interested party. We can go through those briefs and select what we want to get into in greater depth. I have a real concern about being too specific.

Mr. R. F. Johnston: I do not think that would happen. If we are talking about the interim report in terms of what we are looking for as we go ahead, it is not such a bad thing for our own minds and having us thinking about the kinds of question areas we want to move in. I do not think that would restrict the way people will present themselves to us. If they think something else is a crucial issue within that sector and if we are missing it, they will come and tell us, one way or the other.

I just worry about how we actually do this at this stage. There are some basic things one can presume. I think the questions you raised out of the hospital management issue are the questions that come to mind, but I am not sure how carefully they have to be enunciated. I really think it may mean sitting down with the steering committee members and saying, "What are the things we are really after here," and then laying that out, which is a more difficult thing to do here.

It would probably take Ms. Fooks sitting down, drafting something and then putting it in front of people so they have something to respond to. It was easy to respond when we got the list that was just given to us by Ms. Labelle, but I am not sure how I want to limit the discussion.

You are right. The philosophical questions can get begged all the way along this in terms of where we are going with it and why we are doing it. I guess I do not see it as crucial one way or the other, given the two we are dealing with. If you want to try to lay that out, I think that would be a useful thing to do. Is that too loose?

Ms. Labelle: Re-emphasizing that, it might also be important to think about where the data are not sufficient to render a verdict on whether the private initiative is good or bad or whatever. If in the final or in the interim report we say we cannot make judgement on various questions because the data are not sufficient, at least some of the evidence that will come in

in public hearings might help fill in some of the gaps that have been identified.

Mr. R. F. Johnston: I think that is a good reason for doing it. The other thing that comes to mind is in the areas in the Ministry of Community and Social Services where we have deficits in information. Child care is one of the areas where we do not have any long-term information. We are going to try to get them to pull together that stuff by the time we get back.

Ms. Fooks: The child care system was not set up until 1980, so they had nothing previous to 1980 that we could get. We have six years worth of those statistics.

Can I use the framework that Research Innovations and I used to present this to you? Can I use the categories? Are there problems with that?

Mr. R. F. Johnston: No problem.

Mr. Chairman: It is amazing how we have a consensus now that Mr. Andrewes has left.

Mr. R. F. Johnston: He is back.

Mr. Turner: It is a good thing we came to a decision first.

Mr. Chairman: We were just commenting how, since you have gone, we have got a number of consensuses, moving along very smoothly.

Mr. R. F. Johnston: At a future meeting of the steering committee, you will start receiving names of people we think should be brought forward for this, and people from other jurisdictions we might like to have brought to us as well. I am thinking specifically at this point of Alberta, on child care.

Mr. Baetz: In addition to the advertisement, are you going to be writing to some people to invite them to come? Obviously, if you look at the Katie Cooke report, somebody is going to go through that and say, "Hey, here is an individual or organization that had some useful things to say." Is it appropriate for the chairman or whomever to go to them and say, "We would be interested in hearing from you"? Or do you let whomever wants to, come, with no invitations? I like the latter.

Mr. Chairman: We have canvassed every appropriate minister of every province, have we not?

Clerk of the Committee: We have written letters to the ministries asking for parallel information on commercialization.

Mr. Baetz: In addition, there are quite a few people out there who are not necessarily attached to any provincial ministry or even to the federal ministry, who by now have given this subject a lot of thought.

Mr. R. F. Johnston: I think we will have very little difficulty in getting hold of pretty good lists of people to come in on child care, because there has been so much public activity in the whole issue area. The problem is it will be more trying to get people who can come talk to us specifically around this issue of privatization.

Clerk of the Committee: It would be helpful for the drafting of the

interim report if we had some kind of date that you want to have it by. A suggestion from me is that the week before the public hearings start might be appropriate. It would give people at least a chance to look over it and, at the same time, give Cathy enough time to draft it.

Mr. R. F. Johnston: The week before the March break or the week of the March break?

Clerk of the Committee: The week before the March break.

Mr. R. F. Johnston: Two weeks before the hearings. That would be fine. A lot of us will be sitting on the standing committee on social development at that point anyhow and will be around and available.

Clerk of the Committee: Also, we will need a motion to be able to file with the Clerk of the House if we come up with the interim report at that point.

Mr. R. F. Johnston: So moved.

Mr. Chairman: Consensus?

Agreed to.

Mr. Chairman: While Debbie is writing that down, although we have slated four weeks, have you any idea what days you do not want to sit during those four weeks? Mondays have been considered inappropriate for those coming a long distance.

Mr. R. F. Johnston: In the past, we have often had Monday afternoons and no bodies.

Mr. Chairman: I just thought it would give us all an opportunity to schedule anything we wanted to schedule if we could agree now on what days during those weeks we would not sit.

Mr. Turner: Why do not we leave out Mondays and Fridays?

Mr. Chairman: Surely, that is really cutting us down. Would you like to sit Monday afternoons?

Mr. R. F. Johnston: I think we are going to have to sit either Monday afternoons or Friday mornings, one or the other, to get enough done.

Mr. Chairman: Let us try Tuesday through Friday morning and see how that sits with the committee.

Mr. Turner: I would opt for Monday afternoon through Thursday.

Mr. Chairman: Let us try one and then the other.

Mr. R. F. Johnston: Monday afternoons through Thursdays is what has worked in the past when we worked four days. Fridays are impossible days to try to arrange for out-of-towners.

Mr. Chairman: Is that agreeable to the committee as a whole? Agreed.

Clerk of the Committee: Can I call the subcommittee together for agreement on anything I have neglected to take care of today?

Mr. R. F. Johnston: Absolutely. Please call them together as frequently as you can. You have full authority.

Clerk of the Committee: If a member of the subcommittee from any particular caucus cannot make it, can I call the alternate member?

Mr. R. F. Johnston: You certainly can.

The questions now are where we go with our research people between now and then and what we want.

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Dr. Stoddart: That was the question I was going to raise before you all got away.

In the outline, you suggested that prior to the phase 2 hearings you would like to have some kind of a briefing on such literature and evidence as seemed to be out there and what it said on some issues. At that time, we were thinking we would have between November and March to prepare those kinds of briefings. Now we have very few weeks.

It may not be difficult to get a good briefing together in the nursing home-chronic care area if we start now; maybe get a literature review and even arrange for a couple of people to lead off those hearings by invited presentations. It may not be difficult to do hospital management since we have the expert here. It seems to me the area of day care and children's services is an area we will have to start on immediately if you are to have anything, and even then it may not be as large as it would be for the others, especially for the nursing home area.

First, do you want some literature review done and some briefing notes prepared by someone? Second, can we then go forward to try to find someone to do part of that task, as we did with Research Innovations on the inventory?

Mr. R. F. Johnston: My answer to the first question is, yes. My answer to the second question is, what are you doing, Cathy?

Ms. Fooks: I am drafting the interim report.

Mr. R. F. Johnston: Do you think the drafting of the interim report, the way we are now designing it, is going to be such that it will take your time from now until then?

Ms. Fooks: Yes, because the data that have been presented are going to have to be reworked to give, rather than just the numbers, some analysis of the numbers. That will occupy my time.

Mr. R. F. Johnston: If that is the case, I would reluctantly get somebody else to do it. I have to say, however, if I were evaluating the work that has been done for us up to this point, the work done by our own legislative library staff was equal to, if not superior to, that which we received from the other assistance groups. We will therefore need somebody else to help pull together that information for us.

That is my feeling. We should have a briefing for the first day of hearings and go over what has been given to us for that first Monday.

Mr. Chairman: Can I have a clarification of that? Are you talking about using Research Innovations to do that?

Dr. Stoddart: That is up to the committee. That would be one possibility. It is always difficult to get somebody to do a big job on short notice. There is a fair amount of literature out there in the sense that it is scattered and so on. What you are really paying somebody to do is the legwork, rounding it all up and distilling it.

I do not know. How does the committee feel? Would you be averse to using Research Innovations again?

Mr. R. F. Johnston: No. Personally, I was not meaning to make it sound like I was trying to denigrate their work. I was just saying that in terms of the quality, we often get ourselves very caught up here with going to outside consultants for assistance. Although, in terms of the overview, having you two involved has been crucial to us, I think what we have learned is that we can have research done for us very capably from our own resources here when they are available to us. We do not necessarily always have to go outside. That is the only point I was trying to make.

Ms. Fooks: There are 15 research officers in my unit and there are a couple of them who actually have a good background in day care in particular. We could certainly use them, but I am not sure I could commit them. I do not know what amount of time we are going to be using here.

Clerk of the Committee: Can I make a suggestion that, some time between now and the next time the steering committee meets, we get together and possibly decide on some person or group of persons who are consultants, and Cathy and I can come to the subcommittee and ask for approval to use that person or persons?

Mr. Chairman: Is it agreed? Agreed.

Dr. Stoddart: I would certainly agree, and I think Roberta would too, that the quality of the legislative library work is very high in a research sense, both the methodologic qualifications for the research and the actual understanding of the topic therein. We would have no trouble with that proposal at all. If Cathy could produce some minds to go at it, we would be delighted to keep it inside, because it is very high quality work indeed.

Mr. Chairman: We should probably give Cathy a holiday for all that.

Mr. R. F. Johnston: At least one day.

Mr. Baetz: Is it fair to assume that some of the research that will be presented is from outside of Canada; that it will include other jurisdictions, such as in the United States?

Mr. Chairman: Is that a leadup to travel?

Mr. Baetz: No. I had not really thought of that.

Mr. R. F. Johnston: We will definitely need it. The literature is out there and it will be useful to us.

Dr. Stoddart: We will search as widely as we can. You can be sure there will be literature and models of operation that come from different

jurisdictions. In the literature for the first set of hearings, it may not be possible to round it all up in the next four weeks, but by the time this committee deliberates in phase 3, which is its own deliberations, recommendations and report writing, that sort of literature should have been completely rounded up one way or another. I would say a good chunk of it in the main, certainly some of the more controversial pieces, should be available by the first day you sit.

Mr. Chairman: I just wanted to get back to one comment that was made. Are you serious that you want me to write to the House leader and ask for the name to be changed? That stalls a lot of things here.

Mr. R. F. Johnston: No. I think the way Mr. Andrewes has suggested we go around the summer hearings and adding that to our request for ads now, we are putting that to the House leaders regarding our concerns around what the name has done to us in terms of our own attitudes about ourselves as well as the public's perception about us.

Mr. Chairman: But it is not needed for the interim report or the advertising or anything like that?

Mr. R. F. Johnston: No.

Clerk of the Committee: Just within the request to ask for additional hearings in the summer, you would like to flag that the name has been a problem.

Mr. R. F. Johnston: Yes, that is fine.

Mr. Chairman: I think that is everything. We stand adjourned until the call of the chair.

The committee adjourned at 4:57 p.m.

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SELECT COMMITTEE ON HEALTH

COMMERCIALIZATION OF HEALTH AND SOCIAL SERVICES:
CHILD CARE

MONDAY, MARCH 23, 1987

SELECT COMMITTEE ON HEALTH

CHAIRMAN: Callahan, R. V. (Brampton L)

Andrewes, P. W. (Lincoln PC)

Baetz, R. C. (Ottawa West PC)

Cooke, D. S. (Windsor-Riverside NDP)

Cordiano, J. (Downsview L)

Hart, C. E. (York East L)

Henderson, D. J. (Humber L)

Johnston, R. F. (Scarborough West NDP)

Reycraft, D. R. (Middlesex L)

Stephenson, B. M. (York Mills PC)

Turner, J. M. (Peterborough PC)

Substitutions:

Jackson, C. (Burlington South PC) for Mr. Andrewes

Leluk, N. G. (York West PC) for Mr. Turner

McKessock, R. (Grey L) for Mr. Reycraft

Mitchell, R. C. (Carleton PC) for Miss Stephenson

Clerk: Deller, D.

Clerk pro tem: Manikel, T.

Staff:

Fooks, C., Research Officer, Legislative Research Service

Labelle, R., Lecturer, Department of Clinical Epidemiology and Biostatistics,
McMaster University

Witnesses:

From the Social Planning Council of Metropolitan Toronto:

Freiler, C., Staff Member

Miskin, N., Board Member

Simmons, H., Member, Committee for Privatization

From the Association of Day Care Operators of Ontario:

Smith, J., President

Nowack, P., Vice-President and Policy Adviser

From Happy Child Nursery Schools Ltd.:

Hunt, F. J., President

Donoghue, B., Vice-President

Hunt, C., Secretary-Treasurer

LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON HEALTH

Monday, March 23, 1987

The Committee met at 2:00 p.m. in room 2.

COMMERCIALIZATION OF HEALTH & SOCIAL SERVICES:
CHILD CARE

Mr. Chairman: We have rectified Hansard, I understand, and we will commence with the first presenters, The Social Planning Council of Metropolitan Toronto. A list says Harvey Simmons, Nancy Miskin and Christa Freiler. Would you come forward, please.

I don't know whether you could be picked up on Hansard where you are sitting. Perhaps you could say a few words into the mike.

Ms. Freiler: I am Christa Freiler.

Mr. Chairman: All right, Christa. And I gather Nancy Miskin is next to you; is that right?

Ms. Miskin: Yes.

Mr. Chairman: And, of course, can identify -- Harvey Simmons is it?

All right. And who will be presenting the brief, and is there a written brief? You have it before you. You have a written brief before you. Go ahead.

Ms. Miskin: Okay. I would like to introduce each of the people that will be giving portions of the brief. My name is Nancy Miskin and I am a board member of the Social Planning Council. Then on my right is Christa Freiler, and she is a staff member of the Social Planning Council. And Harvey Simmons is on the Committee for Privatization on the Social Planning Council.

Ms. Freiler: Before Nancy and Harvey make their comments, I just want to introduce the Social Planning Council's involvement in this issue of commercialization for those of you who are not aware of it.

In 1984 we published a report called Caring for Profit: The Commercialization of Human Services in Ontario which identified Ontario's increasing reliance on the for-profit sector in provision of health and social services. And one of the things that report did was to point out that the issues cut across individual services and that there are a number of fundamental issues, particularly

with respect to quality of service, accountability, influence on public policy and access, that apply equally to a variety of services.

The report and, in fact, the whole privatization project was motivated by the Social Planning Council's fear that the long-term consequences of commercialization would be negative, and we recommended that there be a moratorium on commercialization until a policy review had been conducted.

This current review by the Select Committee on Health we feel is a very important first step in defining what the future role, if any, will be of the commercial sector, and we want to commend the government on this initiative and welcome the opportunity to address the committee.

The point of this presentation is to stress the importance of taking an intersectoral approach, that is, to look at the issues across all of the service areas and to develop a policy that deals with all of the services. It would therefore be useful to take a closer look at some of the perspectives on commercialization, namely, the arguments for and against, which Harvey Simmons will be presenting before turning specifically to day care.

Mr. Simmons: In Caring for Profits, the Social Planning Council went into depth on the whole question of commercialization of a number of services. So what I am going to do here is just summarize some of the main points that came out of that report and out of other reports that the Social Planning Council has looked at.

The point that we are making here is that the arguments in favour of commercialization of day care are obviously generally made in favour of commercialization in a number of areas -- prisons, hospitals, nursing homes and so on -- and we have summarized the arguments for commercialization under four headings.

First, the argument that for-profit operators can offer services more cheaply than can non-profit providers.

Secondly, that the for-profit sector is more efficient, better managed and more innovative than the non-profit public sectors.

Third, that the presence of the for-profit sector increases consumer choice and competition, which is, of course, integral to any market system, thereby ensuring a higher quality of service.

And for-profit services increase the supply and availability of services.

Now, these arguments are widely made, but our argument is that what evidence there is is contradictory or faulty; and we feel there are formidable arguments against the commercial service provision and these are summarized as follows:

First of all, there is mounting evidence that the quality of service suffers in many for-profit organizations. There is hard evidence for that as well as anecdotal evidence. There is a certain irrationality and inefficiency in subsidizing the for-profit sector at a time when we need tax dollars for other scarce resources.

There is enormous difficulty and expense involved in showing accountability to the community and the government. The commercial sector marshals its resources to oppose regulation in government and to impose enhanced standards by government, and there is therefore insufficient investment in non-profit and government services. Cost savings, typically, are at the expense of staff salaries and other areas where service quality may be affected.

Competition does not and cannot exist as long as the demand for services exceeds the supply. This is not a true market situation. What you have is a monopoly situation, rather than competition, and this applies, for example, as we point out in Caring For Profits, to the nursing home sector.

Allowing the for-profit sector to occupy a prominent position in the provision of services as it does particularly in day care in Ontario has not been without a price.

First, the costly and cumbersome accountability mechanisms and service quality safeguards which the Ministry of Health has had to introduce to hold for-profit nursing homes accountable is one example.

Second, again in the nursing home sector, we have seen the government having to take over the operation of nursing homes because of poor quality. Again in nursing homes, there have been coroner's inquests into deaths in the commercial nursing home and boarding home sector. Unacceptable labour practices in for-profit nursing homes and day care centers, and once again staff salaries were kept low because of competitive pressures from the commercial sector, and this necessarily means lower quality personnel.

The SPC gives qualified support to the argument that the commercial sector has increased the supply and availability of services in Ontario. A growing demand for services such as day care, nursing homes, and homemaking has, to date, guaranteed the commercial sector a role in

Ontario's human services, but we argue this is because of default, because of gaps in services which result from government inactivity, from inadequate funding and insufficient investment in alternative forms of service provision.

Now, the Minister of Community and Social Services has justified his recommendation to give direct grants to commercial day care centers on the basis that 50 per cent of day care spaces are now in the commercial sector and that parents would be denied access if government support were not offered. We at the Social Planning Council maintain that this is a short-sighted solution: it does not address the issue of availability and access to child care, it does not address the problems that exist in the commercial sector as we have noted in great detail in Caring for Profit; it is merely a reactive position in view of the present crisis.

And now Nancy Miskin is going to give you the conclusion.

Ms. Miskin: The present government appears to share our concerns about the quality of service in commercial organizations and the impact of commercialization on service users, workers and the voluntary sector. The government has undertaken several important initiatives to address existing problems, including the introduction of amendments to the Nursing Home Act, the establishment of an inter-ministerial committee on visiting homemaker services and the preference for non-profit, community-based sponsors of proposals for nursing home beds.

The recommendation to extent direct grants to commercial day care centers has reportedly been motivated by a desire to help commercial centers maintain their present level of operation. However, as numerous groups have already pointed out, this move will inevitably result in the expansion of the commercial day care sector with results similar to those experienced in day care in Alberta and in Ontario nursing homes.

The Social Planning Council contents that continued financial and policy support for commercialization poses a serious long-term threat to the government's ability to shape social policy. The more people served by for-profit organizations, the greater will be the government's reliance on the commercial sector to achieve social policy objectives.

Instead of assuming a leadership role in human services, the government may be forced to limit itself to superficial monitoring or to introducing costly mechanisms to ensure accountability. There is already ample evidence from both United States and Canada of the commercial sector's attempts to influence public policy. For example,

past opposition to increase day care standards and the residents' bill of rights in Nursing Homes lend support to the argument that commercialization may be incompatible with government regulation.

The Social Planning Council is committed to the view that day care is best operated on a non-profit basis and that public funds should not go to for-profit centers. Specifically, we recommend two items. One, that a day care grant be paid to all non-profit licensed day care centers and supervised caregivers to be cost shared equally between the federal and provincial governments.

And two, that independent for-profit operators be eligible for the direct grant for a maximum of three years. At the end of this transitional three-year period, for-profit operate would be expected to become non-profit operations in order to be eligible for public money.

And finally, that no government funds be allocated to corporate chains.

In conclusion, we would urge this committee to take a intersectoral and long-term perspective in its deliberations. A policy on commercialization should not be developed on a service-by-service or case-by-case basis. This committee's final report should address the broader social policy implications of commercialization rather than focusing on the behavior of for-profit operators in specific services. Given the risks and the unfulfilled promises, the onus of proof that commercialization is in the long-term best interests the Ontario citizens should fall squarely on the shoulder of the for-profit sector.

Thank you.

Mr. Chairman: There is a bit more of the brief. Is this to be done by one of you people or simply here for our...

Ms. Freiler: We have attached something called the Social Infopac which is a summary of some of the issues in Caring for Profit as well as a discussion of the issues as applied to some of the current events at the time, including privatization of parks, the artificial heart implant and those sorts of things, which is attached to demonstrate the potential for controlling the social policy agenda that the commercial sector has. So this is just for your information.

Mr. Chairman: We will throw you open then to questions of the members of the committee. I do not see any hands yet. Mr. Cooke?

Mr. Cooke: Just a couple, Mr. Chairman. When the

private sector says -- both in the nursing home field and I gather even now to a large extent in the new integrated homemakes service program which now has, what? Sixteen pilot projects, and my understanding is we are getting close to 50 per cent of that being delivered in the private sector -- when they say they are more efficient maybe you can help me. I have never been able to really figure out what they mean by "more efficient."

Ms. Freiler: Well, they are cheaper. Generally what they mean is cheaper and as some of you may know, there is a fair amount of evidence in studies that have been done not only in day care but in homemaking services that if, in fact, they are cheaper, which they are not always, it is at the expense of a variety of things that would lessen service quality, most often staff salaries -- that is the case, obviously, in homemaking agencies in Ontario -- staff salaries, benefits, food in some cases as we have heard in nursing home.

Mr. Cooke: Typically, when a municipality or somebody is contracting out work to the private sector that had been done by the public sector or by the not for-profit sector, the argument is that they are more cost efficient, that government wastes money and all of these things, when the reality is that you are usually moving from, in some cases, unionized decent wages to minimum wage. And, my God, even I could run a business that would be cheaper if I was moving from a decent wage to an indecent wage.

Ms. Freiler: Sir, this is another good example of this. There was a major study in the United States a few years ago that looked at commercial service provision that had been contracted out by municipal governments. And they found that the only service where there was any support at all to the claim of it being cheaper or more efficient was in garbage collection, and that was a study that included a variety of human services, as well. So a lot of the arguments that the commercial sector is using is based on evidence from garbage collection.

Mr. Cooke: The other argument that we hear is that it really does not matter whether it is in the not-for-profit sector or the private sector or the public sector, that proper government regulation can achieve the same quality of care, whether it is in nursing homes or whether it is in child care facilities or whatever the human service that we are talking about. How do you react to that?

Mr. Simmons: Certainly this is a contention. I think there are a number of problems. One problem is it is extremely costly to start imposing public accountability measures on private corporations or private businesses because, first of all, there is conflict involved. Typically, private operators who attempt to curtail any sort

of mechanisms of accountability says there are costs involved.

Second, is the added cost of your having to add to an already existing bureaucracy -- if you are dealing with private operators -- whereas if a non-profit or a municipal organization is already incorporated into government, there is a direct responsibility there that does not incur those costs.

I think the major problem is the one that we mentioned before, that typically the commercial operators will not only fight against any sort of regulations, they will work on the outside, as naturally one can expect them to do, to change the legislation so that accountability measures are weaker than they are. So the cost is the cost of imposing accountability, the extra bureaucracy, and in addition, the fact that you have the political cost of trying to maintain existing standards against those who will try and weaken them.

Mr. Cooke: One of the arguments that you said in your brief that the private sector uses is that accountability is greater in the private sector. Again, that is something that I do not understand because in my understanding of a community-based non-profit group is that they would have a community-based board that is elected by the membership which, to me, builds in two levels of accountability, both with the community as a whole and with the elected board. Can you tell me what the private sector's rationale is of why they have more accountability in their structure, whether there may be a single owner or there may be a number of shareholders that would not know some of the communities from Timbukto.

Mr. Simmons: I think that is the next act to follow us. I do not think that it is up to the Social Planning Council to give --

Mr. Cooke: I have difficulty asking questions to disagree with you because I agree with most of what you said in your brief.

Mr. Simmons: If I can perhaps perform a strong-man act here, if I were were from the commercial sector I would say, in fact, that the customer is always right and if the customer does not like a business in any area, whether it is service provision or whatever, you take your custom elsewhere. That is okay in a competitive market situation, but it simply does not work in an area where you have monopolization of services, where you cannot chose between three nursing homes in the same block like you can between three automobile agencies because there is only one nursing home or one day care center in the area. So the market really does not apply here.

So, in effect, I think I myself do not understand the argument either. I do not think that commercially-provided services are any more accountable, and I do agree that municipally provided or non-profit services have to be much more accountable.

Mr. Chairman: Before Mr. Cordiano goes on, it is my recollection that we have not established time frames we were going to give each group. Traditionally, I believe, it is an hour for groups and a half an hour for individuals, as I recall. I am wondering if we can informally agree on that now and perhaps formalize that after the groups have been heard. Is that agreeable to the committee? All right. Mr. Cordiano?

Mr. Cordiano: Thank you, Mr. Chairman. I want to deal with the remarks that you made on page 2 of this brief with respect to two things; I suppose quality and the question of accountability and, as you put it, the fact that competition does not exist in the commercial sector. With respect to quality, there have been a number of people that have indicated -- in fact, various studies recently indicated -- that indeed quality of -- even in the not-for-profit sector or the public sector -- there are good day care centres in those as well as in the commercial sector and there are bad in those as well as in the commercial sector.

But let us look at the question of staff salaries because indeed we know there are discrepancies between not-for-profit and for-profit with respect to salaries, and there is no doubt about that. If, in fact, we are attempting to address that in the commercial sector, do you not believe that some mechanism could be in place to improve salaries in the commercial sector -- could be put in place to do that? I would like your comments with respect to that.

Ms. Freiler: As you know, the salaries generally in day care are very low regardless of what the sector is, and the municipal salaries are the highest, and that profit centers pay the lowest salaries. And I think one way of dealing with it is to incorporate as a non-profit, organization and to not take that money in profit. You are going to be hearing a lot of briefs from day care groups that follow us that are going to be arguing that virtually all of the money that goes into a day care center goes into things like salaries and that sort of thing. There is not a lot of scope --

Mr. Cordiano: Something like 80 per cent?

Ms. Freiler: Right. That is the figure that I have heard, too. There is not a lot of scope for making a

profit; right? So that if profit is to be made, it has got to come out of something. Where it has been coming out of is salaries primarily and to some extent programming. So I think the approach that we are suggesting is that this direct grant that Mr. Sweeney is recommending be paid to the commercial centers go to them for a three-year period during which time they then have the choice of converting to non-profit status.

Mr. Jackson: Can I supplement that?

Mr. Chairman: Supplementary, Mr. Cordiano?

Mr. Cordiano: Yes.

Mr. Jackson: If I could just follow on that point, I am trying to understand that this direct grant would evaporate in the third year, but then the operator may choose to stay in operation. And the parents would then be faced with a choice of being advised that we can no longer accept your child at this rate because there is a piece of legislation floating out there that says that I no longer get the grant because I am not a non-profit.

What impact does that have on the families and the children? You set out, I think, in your suggestion that they should then become non-profit. Let us assume in a free society that we cannot impose that, we still leave that option to the operator. In my particular region, we cannot find anybody to take non-profit -- only the profit ones -- so if they left the market we would have nothing. So my question is what do we tell the families who are now told, "Here is the new rate because the previous dollars that were given to--"

Ms. Freiler: I think we are working under different assumptions. I am assuming that it would never come to that.

Mr. Jackson: So why did you recommend it then?

Ms. Freiler: It would never be a question of then having to tell families. I think what would happen is that during that three-year period, obviously government has some responsibility to ensure that the non-profit sector, and to a lesser extent the municipal sector, is out there providing the services.

I think as we pointed out in here, one of the reasons we have got such a large commercial sector in Ontario is because there has not been enough support given to the non-profit sector.

The other point is that we are not saying there should be no more commercial centers, just like you have got a

private school system. So the parents who want to opt for having their kids educated in a private school system can do so, and that private school system coexists with the public school system.

Mr. Chairman: Mr. Cordiano?

Mr. Cordiano: I suppose that in the long term one has to ask, well if we are going in a transitional stage from one to the other, we do have, as you have pointed out -- it is fairly clear -- we have 50 per cent of all day care spaces in the province run by commercial operations.

I suppose what one has to address is the question of quality and various other issues that keep coming up in all sectors, and I would like to turn to this question of monopolization that you point out in the commercial sector that, in fact, there is no competition because the lack of services exceeds the supply.

And that leads to the next argument that you made with respect to regulating that industry. You do not believe that it is possible to regulate that sector as effectively as, for example, we would regulate Bell Canada or various other monopolies?

Mr. Simmons: No. What I think the Social Planning Council's position is on this is that non-profit organizations with community-responsible boards -- it is not like Bell Canada -- would be more responsible than would commercial operators. You could, I suppose, hypothetically have the commercial sector deregulated like Bell Canada, but we are not talking about telephones; we are talking about human services.

And so I think the argument here is rather than taking a second best solution, that is government regulation of commercially-provided services, why not move to the best solution which is to move all the way to some sort of non-profit provision of services with direct accountability to the public community boards.

Mr. Cordiano: Fine. That is the ideal and in a perfect world those things would work. But let us deal with the reality in Ontario today. How do we deal with that reality and how do we come to grips with the immediate needs in our community which are growing every day by leaps and bounds, and how do we best address that in the next foreseeable future?

Ms. Freiler: I think that is really a good question, and that is why we are suggesting that three-year phasing out or a three year transitional phase. We are not wedded to the three years; it could be two or it could be four maybe.

But as we pointed out, to give, to extend, policy and financial support to commercial centers right now is a short-term solution that deals with the crisis that exists right now that we are all going to pay for five years, ten years from now. I think a good example of that is what we all saw happen with the previous government to some extent, a situation that the current government is trying to rectify.

This government inherited a massive nursing home system that it now has to spend a lot of money to regulate. It now has to put out public tenders in newspapers that call for preference to be given to the non-profit sector to rectify that imbalance. And I think if more foresight had been applied to that situation, we would not have a situation where 90 per cent of our nursing homes are run for-profit.

So what we are suggesting is that we want to avoid that kind of situation, and one way of avoiding it is to deal with the situation from a longer term perspective now. If they need the money right now, give it to them right now, but make it short term, have other things happen during that transitional period, like more support for the non-profit.

Mr. Cordiano: Then let us address the other question of growth in the commercial sector, and there are various graphs floating around with respect to growth in the commercial sector. The best figures we have are that the growth in the commercial sector, in fact, has not kept pace with growth in the not-for-profit and public sector; that is far outstripping the commercial sector in the last three, four years.

Ms. Freiler: It is true with respect to non-profit. I do not think it is true with respect to public --

Mr. Cordiano: Non-profit. I lump those two together, yes.

Ms. Freiler: The public is dwindling drastically.

Mr. Cordiano: So the whole question here becomes one of addressing what exists and trying to maintain quality in that sector because we cannot replace it overnight.

Ms. Freiler: This is so. I think we would agree, and we would probably say, "Continue to do what is being done." That is, "Continue to support the non-profit sector."

But to now suggest that the direct grant be given to commercial centers permanently I think would turn that trend around. I think that is what the prediction is. What government would be inviting is a massive expansion of

commercial day care centers.

Mr. Cordiano: I do not see how that follows with respect to the direct grant to the commercial sector. If in fact the government moves to have a direct grant to the commercial sector for specific targetted areas, such as salaries or improving quality, et cetera -- a little more specific on that. But I do not see how that is going to allow the commercial sector to grow by leaps and bounds. We are trying to address -- if in fact the government moves in that direction -- trying to address some very specific issues. So I do not quite see how that argument follows.

Ms. Freiler: I do not know how much time we want to take for discussion. If you look at the trends, and I have not seen this interim report but from the work that we did a couple of years ago -- we looked at some similar information as what you have been looking at -- we saw that there were two impetuses for the development of the commercial sector in Ontario.

One was when there were large gaps in services, as Harvey mentioned, or inadequate funding, for example, where you had the commercial sector springing up because no one else was there -- boarding homes, rest homes, nursing homes, to some extent all of the services we are talking about.

But the second major impetus was an infusion of government funding, and that is how come we have got so many commercial homemaking agencies. When the homecare program started to spend more money, all of a sudden the commercial sector saw that there was a way of making money that they previously had not been making.

The same in other provinces. When provincial government money starts getting put into services, what you see -- the first thing you see -- is an expansion of the commercial sector. You just have to look at other service areas.

Mr. Cordiano: I am just trying to look at it in a more specific sense to come to the conclusion that if in fact the government moves ahead with direct grants to the commercial sector for the purpose of increasing salaries in that sector, how would that allow the commercial sector to then expand and grow from there? That is what I do not quite understand. It is very difficult for me to see how that would happen in specific terms.

Ms. Freiler: I am not sure how you could ensure that it was going to be spent on salaries anyway. I have not seen any detailed proposals, but I suppose that would be another reservation.

Mr. Chairman: I think at this point, Mr. Cordiano --

Mr. Cordiano: Okay.

Mr. Chairman: I have Mr. Baetz and Mr. Mitchell, but we are going to take Mr. Baetz and then we are going to let Ms. Labelle ask a few questions. I want to make certain that I have one from each party asking a question before we ask Ms. Labelle. Mr. Baetz?

Mr. Baetz: Thank you, Mr. Chairman. This is somewhat of a supplementary, I suppose, but on the bottom of page 5 and the top of page 6 you have made a statement which I have some considerable difficulty with and I wish you would expand it for me.

You say here that:

"The Planning Council contends that continued financial and policy support for commercialization poses a serious a serious long-term threat to the government's ability to shape social policy."

Then you go on to say:

"Instead of assuming a leadership role in human services, the government may be forced to limit itself to superficial monitoring or to introducing costly mechanisms to ensure accountability."

I wish you would elaborate on that a little more because, as I say, I have a real difficulty on that one because I can think of ten thousand ways in which government intervenes in all kinds of ways to shape policy, whether it is in the social service field, whether it is in the energy field, whether it is in the consumer and commercial relations field. All across the board, government does in fact shape policy, in many cases controls the purse strings.

Now, why do you feel -- and I am not arguing with you, but you have to convince me -- why do you feel that in this particular segment of our society, government would simply then have to stand back and have its policies shaped by these commercial operators?

Mr. Simmons: Only to reiterate what we said before and that is that if government withdraws to the extent of leaving space for commercial services, commercial services would take typically, and have in the past according to the studies that have been done, put pressure on government; for example, to reshape accountability and to reshape standards mechanisms.

Mr. Baetz: Re-shape the mechanisms?

Mr. Simmons: Just reshape the mechanisms by which the

standards of these services are judged. This is happening, I think, in Alberta where day care operators are putting pressure on the government to relax standards. It has happened elsewhere as well, and I refer you to Caring for Profit.

So in that sense, what you would get would be direct pressure on the government, as we have said, to relax and to relinquish standards. It seems to me that when you have commercial operators providing human services to the extent that the accounts of those firms are kept secret, to the extent that parents do not have the same influence they would have, for example, in non-profit provided services, to that extent there is less public information and less ability for the public and for the government to know what is going on.

Mr. Baetz: Well, I must say, having said that, I must now say I have even more difficulty understanding that. But we are not here to debate, Mr. Chairman; we are here simply to hear your presentation. And I guess we will have a chance with the committee to hear more on that particular point of concern.

The other question I have here is the makeup of the council. You are a membership organization plus your staff and your research and so forth -- having been in the field I do know a little bit about it -- but I do not know the makeup of your council at the present time. In your membership and on your board do you have for-profit day care operators?

Ms. Freiler: No.

Mr. Baetz: You do not. But you do have non-profit day care operators or people who are in the field?

Ms. Freiler: Yes.

Ms. Miskin: We have people from a wide range, a cross-section really of Metro Toronto. We have people from family services associations, children mental health centers, academics. We have people across the board from different ethnic backgrounds working in different multicultural groups, different areas working with families and children.

So we have a wide range of people from just about all sectors. We do not currently have anybody that is working in the day care area specifically in their job on the board, but working in and around with families and children and we are hearing the concerns of the community and of the people that come forward expressing their fears -- some of them family -- and some of their questions around the quality of services when it is affecting the children of the future.

Mr. Baetz: But in making your proposals as to between for-profit day care and not-for-profit, the fact remains on your membership --

Ms. Miskin: We have no one for-profit on, no.

Mr. Baetz: Okay. That is what I am saying.

Ms. Miskin: Or no one for non-profit either. We have no one on either side currently working on the board right now.

Mr. Baetz: Well then, in your membership, do you have day care agencies in your membership or directors of individual agencies who you would have --

Ms. Miskin: Membership that receive information about the work, yes, we do.

Mr. Baetz: But do you have in your membership for-profit day care?

Ms. Miskin: No.

Mr. Baetz: I see. So I would imagine that they would be a little concerned maybe that their voice is not being heard through your council; is that --

Mr. Chairman: That is kind of a rhetorical question.

Mr. Baetz: That is a rhetorical question.

Mr. Chairman: Well, if the answers is "No" to that, I will be very surprised.

Ms. Freiler: Well, anyone can become a member.

Ms. Miskin: Anyone can become a member.

Mr. Baetz: Oh, I realize everybody can be a member, but they are not.

Ms. Miskin: By their choice.

Mr. Baetz: By their choice, yes.

Ms. Freiler: We are a public-interest organization.

Mr. Chairman: Mr. Jackson had a brief supplementary. I hope it is brief, because I want to have Ms. Labelle speak.

Mr. Jackson: It is just the final third point that no government funds be allocated to corporate chains. We have

finished three weeks of work on the Nursing Home Act where we addressed this concept, and to what extent have you been advised whether or not any government action along those lines would sustain themselves in the court? It is great to recommend it, but I do not think it is legal. That is what I am asking. Have you checked that out?

Ms. Miskin: Shakes head. (Negative)

Mr. Chairman: Ms. Labelle, would you like to ask a few questions?

Ms. Labelle: I have a couple of questions. I would ask you to clarify and expand upon some of the statements you have made. Obviously one of the primary interests in all these hearings is indications that the private for-profit sector has for the quality of care provided. You make a statement on page 4 that says:

"The mounting evidence that quality of service suffers in many for-profit organizations."

We have been searching out the evidence on that statement lately, and obviously what we need is evidence that the quality in for-profit is less than the quality provided in not-for-profit, either private or public. Do you have evidence with respect to child care that the quality in for-profit facilities is less than that in non-profit counterparts?

Ms. Freiler: Well, I think we probably have access to the same reports and stories that you do.

Ms. Labelle: I will ask you more directly, then. Do you have evidence that the quality differs and is less in for-profit facilities?

Mr. Chairman: Excuse me, Ms. Labelle. I wonder, Ms. Freiler, if you could lean over dramatically to that microphone. We want to preserve your statements for posterity.

Ms. Freiler: All right.

Mr. Chairman: Sorry, Ms. Labelle.

Ms. Freiler: I think there is evidence, and we are not the quality of day care expects, and that was not the perspective we wanted to bring to the committee. And I think you are probably going to be hearing a lot in the next few days from people who are much more up on the specific research.

What we have seen and what we have been reading about lately is that commercial day care centers, as commercial

nursing homes, are over represented in the worst quality of care cases -- so that is one way of looking at the evidence -- which means that commercial day care centers and commercial nursing homes and whatever else are not always worse than their non-profit or public counterparts. However, they are over represented in the worst cases and there have been studies done. There are plenty of studies that show that staff turnover is worse, that staff salaries are lower, that there is just generally less continuity in day care centers. As you know, it depends on what you choose to consider indicators of quality.

Mr. Jackson: It depends on which program.

Ms. Freiler: Well, as a parent of a child in day care, for example, I would think that having high staff turnover is very important. For a little kid, it is really important to be in a day care center where he or she knows the people from one month or one year to the next.

Mr. Jackson: They do not do it in the public school system.

Mr. Chairman: Mr. Jackson --

Mr. Jackson: I am sorry.

Ms. Freiler: Well, I think that is probably not true, actually. I think probably if day care --

Mr. Chairman: You do not have to answer that question.

Ms. Freiler: Well, no; but I think it is a good point. My guess is that if day care staff were paid anything like what public school teachers were paid, you would not have the problem. As long as you have got a powerful and large commercial sector, you are not going to have day care staff paid that.

Mr. Chairman: Ms. Labelle, do you have a further question?

Ms. Labelle: Yes. I think the research staff would like to contact you after this hearing and discuss with you that evidence because we are trying to collect as much as possible.

One of the suggestions you make that no government funds should be allocated to corporate chains, is that because you believe that corporate chains are making a higher profit than single proprietors in the not-for-profit field?

Ms. Freiler: Well, I do not think it is not just that

we believe it; I think that is the case.

Ms. Labelle: Do you have evidence for that again?

Ms. Freiler: We could get evidence.

Ms. Labelle: Great.

Ms. Freiler: It is not just because of the high profits -- and I think this is an important point to make -- but it is because the potential for the kind of control and anti-regulatory action that Harvey was describing is far greater when it comes to corporate chains.

What you have in the Association of Day Care Operators of Ontario is, of course, is that both kinds of commercial operators in the United States and in Alberta, it is the corporate chains who have the ability for organizing themselves into powerful lobby groups that, according to our review, pose the greatest threat with respect to influencing public policy.

Ms. Labelle: We would again be very interested in that evidence. We need actual imperical evidence instead of anecdotal evidence, so we would appreciate that.

Two more quick questions. You you said there is evidence of anti-regulatory reaction to the private sector; and although I do not want to get into nursing homes right now, you site the residents' bill of rights in nursing homes as an example of that. Would you explain that, please?

Ms. Freiler: I am going by recent newspaper articles in both the Globe and Mail and the Toronto Star that quoted to representatives of the Ontario Nursing Homes Association -- I think specifically Harvey Nightingale -- as being quite critical of the residents' bill of rights. As I recall he had nothing good to say about it and felt that it would impose a major hardship on nursing homes if the implementation were to --

Mr. Jackson: That was along the Liberal government's position for several weeks, Mr. Chairman.

Ms. Labelle: Last question.

Mr. Chairman: We will call that an anecdote.

Mr. Jackson: That was an anecdotal comment as well.

Ms. Labelle: Your statement that because demand exceeds supply, there is no competition as we would like to see it, and that, in fact, a monopoly exists in the industry. By that do you mean that you feel there is no competition among the individual private for-profit

operators?

Mr. Simmons: There can be competition between individual for-profit operators, but within any particular neighbourhood or any city or town, the competition does not take the form of customers vying with one another through competing something services. I suppose the competition that you are talking about takes place at the level at which one tries to get contracts to locate in an area. But once one locates in that area, one has a monopoly over the potential customers in that area for want of some alternative service.

Ms. Labelle: So that the location of a day care operator in a single area you believe gives him monopoly power over the clients, that they have no alternative?

Mr. Simmons: Yes. In some areas where there are no alternative day care centers which are reasonable for the parent to send their child to, yes, that gives them monopoly service.

Ms. Labelle: What do you think the frequency of that type of occurrence where there is a single provider of care in an area unchallenged by other for-profit or not-for-profit operators?

Ms. Freiler: I think that is extremely pertinent. If you look at a distribution map of Metro Toronto, for example -- and that might be something that you might ask your research staff to get you -- you can see where the commercial day care centers are located. They are located in particularly Etibocoke, Scarborough -- not a lot in the City of Toronto, for example. If you happen to be living in Rexdale, for example -- and that may not be the best example -- you do not have any choice unless you want to drag your kid downtown, but to take that child to a commercial day care centre.

I mean, I think that supports Harvey's point that that person has virtually no choice, given that most parents choose a day care center that is either near where they live or near where they work, and you do not have the choice of driving all over Metro Toronto. Plus there are no empty day care centers, and that is the other problem, of course.

Mr. Cordiano: Mr. Chairman --

Mr. Chairman: Excuse me a second. Are those your questions?

Ms. Labelle: Nods head (affirmatively).

Mr. Chairman: I held off with Mr. Mitchell, and I am going to let him go first, and I am going to let you have

your supplementary, Mr. Cooke, and you have your supplementary, Mr. Cordiano. I believe Mr. Jackson asked for a supplementary as well.

Mr. Mitchell: Thank you, Mr. Chairman. First off, a couple of comments. I too am a little concerned when you use statements such as you do that "mounting evidence shows --" so and so. Because I think the responsibility is on you, once you have made a comment like that, the responsibility then is on you to provide information at the time you submit the brief.

I do not think you can go on the type of answer that you provided to the question that was asked. I think that if you are going to say, "mounting evidence," then you had better be prepared to back it up and back it up at the time of submitting your brief.

Secondly, you used the example of the nursing homes and the bill of rights and so on. Well, surely the fact that that bill of rights came about in the latest committee deliberations shows that in fact the government would still be exercising that leadership role vis-a-vis the question that Mr. Beatz asked. So I think in that sense you are also being very contradictory to the position you have taken.

But I am still not sure --

Mr. Chairman: Perhaps we could stop there.

Mr. Mitchell: All right.

Mr. Chairman: If that is a question that anyone cares to respond to, we will give you an opportunity to do that.

Mr. Simmons: Maybe I can respond briefly. If you take the nursing home sector as an example -- the homes for special care as an example -- the program started, if I am not mistaken, in 1963 and 1964. That is already twenty-three years. During that time there have been a series of investigations, scandals, problems, attempts to further regulate nursing homes and homes for special care. There is no doubt that government has been trying to take a leadership role in this, but frankly it has had major problems in dealing with the homes for special care in the nursing home sector.

And I think this is another example of what happens when you have a sector which is largely dominated by commercial interests in which government has to take the reactive role. That is, until scandals occur, until problems occur, government on the whole, because it has scarce time and resources, will devote its attention to something else. It then tries to catch up against the resistance of those who operate the homes, as we have

pointed out.

Certainly the bill of rights for nursing home residents is a positive step, but this will again be just another fight to improve the quality of nursing homes, but one doubts very much whether this will finally solve the problems, the perennial problem, of how one deals with commercialization in this area.

Mr. Mitchell: The Chairman would accuse me of getting into a debate, so I do not intend to do that. However, there is always a possibility that your not-for-profit day care centers, one of them could turn out to be bad.

I am still not sure about the question raised by Mr. Jackson -- the answer to the question raised by Mr. Jackson. In fact, what does happen to those for-profit spaces at the end of that third year, assuming that they choose to hold out, that they are not prepared to accept that restriction that they do not get the government money? Are you suggesting that the government go and buy them out? What are you suggesting should happen, because I am not clear on what you are saying.

Mr. Chairman: I suggest that go not-for-profit.

Mr. Mitchell: Well, I realize that, but I am saying we cannot force them into that. What if they choose to close out?

Ms. Freiler: I am sorry; I thought I had answered that. And that is that they can still exist.

Mr. Mitchell: Yes, I realize that -- charging the higher fee.

Ms. Freiler: Charging the higher fee, just like you have got private schools.

Mr. Jackson: Supplementary. Would we still not have to regulate those? I mean, this mounting bureaucracy argument, if that is part of your long-range window onto the issue in Ontario, would that still not require a parallel structure of regulation and enforcement?

Ms. Freiler: Our recommendation is based on the assumption that if public money were not forthcoming or were given only for a limited three-year period, commercial day care would not be that attractive to very many day care operators.

I guess we are taking the opposite line from what I was arguing before, and that is if you give government money, it is making it attractive; you are inviting expansion. Our assumption is that if you do not give

government money or you just give it for a three-year period, you will make it considerably less attractive to be a commercial operation, and many of the smaller independent operators might then choose to become non-profit operations. And if at the same time you are supporting the non-profit sector at the end of that three-year or five-year or whatever period, there should not be a problem. I think that is part of the planning process.

Ms. Miskin: I was going to add to that. I think, too, the example of the three years was one way, and it is not the only way. I think that the point we are making is to encourage not-for-profit and to not expand on the profit day care centers for the various reasons that we have given. And we were looking at one possibility and the strategy for that, not saying that the book is closed and that is the only strategy. I am sure there is many strategies that could be developed to encourage more not-for-profit and to not expand in a large degree the commercialization of day care as you have in the nursing homes.

Mr. Mitchell: I am sorry I am going to let it pass Mr. Chairman, because I still do not feel that the answer is there. You are saying that it becomes less attractive to the private operator. If it is less attractive, if they cannot operate as a not-for-profit, then those spaces could be lost. And what I am asking for is where do those spaces suddenly come from?

Ms. Freiler: They should not have to suddenly have to come from anywhere. I think that is a point we are trying to make. Part of the reason you have the government so dependent on the commercial sector -- In a way, your very question I think supports our point that the government has been relying increasingly on the commercial sector to the extent that in some cases the commercial sector has been able to hold the government to ransom.

I think that is what we have seen in nursing homes where you have got 30,000 beds in the commercial sector with the Ontario Nursing Homes Association threatening to pull out of the business if they did not get more money. What you are doing is setting up a situation where you are going to see a repetition of that in day care.

The spaces should not suddenly have to come from anywhere. There should be an attempt now by the government to support and encourage the non-profit sector so that when -- I guess we are talking about two things occurring simultaneously. I certainly do not want to trivialize your question because I think it is an important question, it is just that there are other ways of dealing with the spaces rather than the one that current government --

Mr. Mitchell: I guess I was not particularly leaning

in the right direction to follow that particular -- that intermediate step that you have just talked about.

Ms. Freiler: It may be that the government feels it needs a longer transitional step; it may not be able to rectify that balance and boost up the non-profit sector enough in three years. But I think if we are suggesting it as a more constructive alternative than what is being proposed now, that seems to put no time limit on how long the commercial sector is going to be financially supported.

Ms. Miskin: I think, too, we are basically saying take a longer point of view on this rather than our crisis-oriented or reaction-oriented often policies that come forward as a reaction to bad quality service. Let us try to look a little bit ahead of ourselves and develop some good quality services so we do not have to be in a reactive position, putting out more money, more dollars and more regulations. If we get it right the first time and take a long-sighted view rather than short-sighted, we might develop a better human service area for the area of day care.

Mr. Chairman: All right. Mr. Mitchell, we have an hour set aside -- in fact, we did decide on that -- for groups and I do not want to lead into the next group's time.

Mr. Cooke and Mr. Cordiano, do you have a brief supplementary? I do not want to restrict you at all but --

Mr. Cooke: I agree with your concerns about the time, but I just wanted to clarify one point that was raised by Ms. Labelle and that is dealing with competition, because I am not sure that you were entirely clear. But I think I understand the point you are making.

In my community in Windsor, if I want to get someone -- if a family needs to have a child in a child care center, the options that I have available open to me to help that family is to take the first spot that is available regardless of where it is in the city. And that could be on the west end even though my riding is on the east end. But the fact is you put your name on a list and you can put your name on every child care center list in the community and you take what comes available.

So, isn't that really what you are talking about in terms of competition, that there cannot be competition when you have to take the first thing that is available.

Mr. Chairman: I see a nod yes. Mr. Cordiano?

Mr. Cordiano: Well, I think, in the interests of saving time, I will not go on because it might take a little further. I am going to open up another issue here, but very

briefly, Mr. Chairman --

Mr. Chairman: I thought you were withdrawing your question.

Mr. Cordiano: That is why I said "very briefly." The whole question of subsidization you never addressed that, or I believe you never did, with respect to commercially-run centers. Do you have any thoughts on that?

Ms. Freiler: You mean with government money?

Mr. Cordiano: Well, subsidized spaces, because that cuts across both not-for-profit and for-profit.

Ms. Freiler: Well, I think our policy that no government money should go to commercial day care centers at the end of three years would apply to subsidies.

Mr. Cordiano: But surely to God we have 33 per cent of all the spaces in commercial centers that are subsidized.

Ms. Freiler: Sure. But it is exactly the same argument as saying we have 50 per cent of all spaces in commercial centers.

Mr. Cordiano: Okay; but three years?

Mr. Chairman: That was just an alternative.

Mr. Cordiano: I am thinking about what you are saying as a transition stage. You said that perhaps three years is not long enough, but I am just pointing out that there does exist this huge number, and in fact that is a realistic area that we have to be concerned about.

Ms. Freiler: We are suggesting an approach and we are not wedded to the time periods.

Mr. Cordiano: No. I just wanted to point that out because if you talk about subsidy then you are looking at 33 per cent of those spaces that are actually subsidized by --

Ms. Freiler: Well, when we developed this policy we were also aware of the fact that the federal government as well as the provincial government were going to be reviewing the whole way in which day care was going to be provided. That, obviously, is part of the whole picture.

Mr. Cordiano: Yes. And we have not raised the whole question of affordability with respect to all of this, and certainly that has a great deal to do with what we talked about.

Mr. Chairman: I think you are moving out of the

supplementary field, Mr. Cordiano.

Could I just ask one quick question. I gather your evidence is restricted to Metro Toronto, since you are the Metro Social Planning Council.

Ms. Freiler: Shakes head (negative).

Mr. Chairman: No? Okay; that is good enough. No. And just one quick question, if you are all not-for-profit, how did you regulate quality? If there is no competition; if they are all not-for-profit or on the other side of the coin, if they are all for-profit, how do you regulate quality?

Mr. Simmons: I would rather be on the board of a parent-regulated, a parent-run nursery school where I can have my voice once a month or once every six months and make a veiled but obviously phoney threat to pull my kid out of a commercial center. It seems to me that the participation that would be involved, and usually is involved with non-profit centers, is the best guarantee of quality.

Mr. Chairman: You are saying because the parents are on the board and involved?

Mr. Simmons: Yes.

Mr. Chairman: Okay. Thank you very much. I would like to thank you for coming forward. The brief you presented was very interesting, and we wish we had more time to continue. Unfortunately, we have two other presenters today. Perhaps if we can spread them out a little more -- I do not know -- but thank you very much for coming.

Mr. Freiler: Thank you.

Mr. Chairman: The next group is the Association of Day Care Operators of Ontario, and the clerk is passing out a brief to you on behalf of this group.

I understand it is Jeff Smith, President, and Pat Nowak, Policy Advisor. Are they both here? All right. If you come forward, and it is important, as I explained before to speak into the microphones so we have your thoughts accurately recorded. Perhaps I can inquire who will present the brief and whether you will be reading from a brief or whether you will be giving us a precis of the brief.

Mr. Smith: Mr. Chairman, I will be reading the brief, and I would like to read the entire brief into the record, if I may.

Mr. Chairman: All right. And then we will have the time for questions.

Mr. Smith: Thank you.

Mr. Chairman: Go ahead, Mr. Smith.

Mr. Smith: Thank you, Mr. Chairman, and good afternoon, ladies and gentlemen. Once again, my name is Jeff Smith. I am the President of the Association of Day Care Operators of Ontario. With me today is Pat Nowak, a long-time member currently holding the position of Vice-President and Policy Advisor for the Association.

I am going to read our entire brief into the record today including the covering letter. It does not contain any specific policy statements, as we felt that this committee was more concerned with the overall ideas and issues surrounding commercialization rather than specific issues dealing with the policy of providing child care. If, however, you wish to ask questions later on, we are certainly ready to answer any of those questions.

Dear sir, I am writing to you today to thank you for your interest that your committee has expressed in the views and opinions of those people who have not only sought out the entrepreneurial spirit of our country by borrowing and investing money, creating jobs and paying taxes, but taken the personal risk of placing their future on the line to provide a service so badly needed in our country. These people are good citizens and so are the 50,000 families that depend upon them. Their voices deserve to be heard.

Ontario has long been a leader in North America in the provision of child care services. Your conclusions will be listened to carefully, not only in Ontario but throughout Canada and the rest of North America. Your recommendations will set the direction of human services for the foreseeable future in this country.

The questioning you have been asked to consider is not an easy or clear-cut one. It is emotional and not only touches moral and ethical issue but historical and ideological ones as well.

The Association of Day Care Operators of Ontario has also had to ask itself this same question. A great deal of thought and self-examination has been done by each and every member. The question has been raised in the media so often that if this were not done, our members could not remain in business with a clear conscience.

Our answer is this: Any system of human services needs a mix of all types of auspices of care. The provision of commercial care must be done with a social conscience. I believe our members have this social conscience; if they did not, fifty thousand families would not depend upon them.

Outlined in the following brief is a rationale to our answer on commercialization of human services. I am confident that you and your committee will consider them seriously. I know your committee will look beneath the rhetoric and emotional pleas that you will hear throughout your work and seek out the best possible solution for the people of Ontario. By providing the best possible care for the children of Ontario, we ensure ourselves a strong and stable future.

Once again, thank you for listening to the voice of the commercial sector of the child care community.

History and Profile: The Association of Day Care Operators of Ontario, known as ADCO, is a non-profit incorporated association. Our membership consists of licensed proprietary persons, firms and corporations. Their principal activity is to provide child care services to the public of Ontario. Our members are drawn from the community of child care providers and represent a broad spectrum of child care services.

Established in 1977 and originally known as AIDCO, the Association of Independent Day Care Operators of Ontario, the association was formed when a group of operators realized that they could improve their centers through shared experiences. They also realized that the growing voice of certain groups who would like to see all child care operations completely government operated could soon falsely taint the public's image of private operators. Unless they spoke out as a group, they could be seen as uncaring, profit-orientated entrepreneurs. This would not show the true picture of the child care community.

The association stayed relatively small for the first five years and concentrated on local problems. However, as the members gained confidence and expertise in their ability to deal with the complex problems surrounding child care, the association began to grow until it has reached the state it is in today, that of one of the leading voices of child care advocates in this country.

The name change from AIDCO to ADCO came about when some operators, realizing the growing need in the community, opened second and third centers. In the interest of public honesty, the word "independent" was dropped.

ADCO's greatest single accomplishment was the spawning of a national organization known as the Canadian Child Care Management Association or the CCCMA. This came about when a group of members formed a special committee to look at the need to lobby at a federal level. This committee soon realized that the federal government would need to be actively involved in the provision of child care and that

there was a definite need for a national voice of private operators. The committee then expanded from ADCO to form a nucleus of this national organization.

Throughout the years, ADCO has presented briefs to several committees and task forces. As well, lines of communication through interviews and committee work have been set up with the province, municipalities, community colleges and other interest groups.

Our members' centres vary in licensed capacity ranging in size from 20 to 244 children. They are located throughout Metropolitan Toronto and include the areas from Scarborough to Etobicoke, Peel, Halton, and as well some smaller communities. Our physical space varies. Centres are located in apartment buildings, schools and churches and various purchased and renovated buildings.

We have members who have operated centres for as long as twenty-two years. Many owner-operators are ECE, Early Childhood Education teachers, who have dedicated themselves to their field and sought out the spirit of free enterprise by obtaining their own center.

Many of our members hold purchase of service agreements with various municipalities. This agreement provides for the enrollment of subsidized children in their centres.

Our membership, to date, includes 100 centres caring for approximately 7,182 children and employing over 1,330 staff members. As well, we have numerous associate members who represent various industries associated with and interested in the child care field.

The majority of our members are single-center operators. The next largest portion of our membership is made up of former single-center operators who have opened second, third and fourth centres to meet the ever-expanding community need.

In percentage terms, our membership breaks down as follows: single centres, 58 per cent; two centres, 15.5 per cent; three centres 10.25 per cent; four centres, 10.25 per cent; five centres or more, 5 per cent.

It is therefore obvious that ADCO is dominated by single-center operators and any myth that suggests ADCO is comprised of large chains and uncaring intreprenuers is totally false. In fact, if we meet our 1987 membership goal, our research shows us that single center percentage should increase dramatically. The majority of operators with two or more centres are located primarily in Metropolitan Toronto area, which make up a major part of our membership base.

Based on research printed in the Report of the Task Force on Child Care, chaired by Dr. Katy Cooke, this means that ADCO represents 43 per cent of all licensed group care in Ontario, and 14.75 per cent of all children in Canada in licensed group care. However, the latest statistics indicate that the commercial sector now accounts for 50 per cent of all children in licensed care in Ontario.

ADCO is the only united voice representing private enterprise child care services in the child care community throughout Ontario.

The most vital purpose of our association is to provide a forum amongst members for sharing information that will enhance their ability to operate quality programs.

This is accomplished by several means. We publish a newsletter which includes such information as nutrition, staff management, marketing, purchasing, renovations, et cetera. In addition, we have informative speakers address the association. In the past we have had the Honourable John Sweeney, Minister of Community and Social Services, a representative from Seneca College who specialized in work sharing and varied work hours, a member of the Homes for the Aged society speaking on lobbying techniques, and a lawyer speaking on labour law. As well, we have general meetings to discuss individual operator's problems and concerns and reception meetings for sharing of ideas and experiences.

The secondary purpose of the association is to lobby government bodies, both municipal and provincial, in order to enhance and expand child care in Ontario and to ensure a continued place for private operators within the Ontario child care community.

The Issues: ADCO members are committed to the common goals of enhancing the quality of child care services and safeguarding private enterprise in the child care movement.

Ontario has played a strong leadership role in the whole of Canada in the establishment and development of standards for child care services. The private operators in the traditional provision have been very much a part of the delivery of this high quality.

Our broad range of representation of our membership provides an expertise in child care services that is based on experience, survival in the competitive business community, non-reliance on government funding, and, most importantly, our commitment to quality child care services.

Quality Child Care: Quality is a commitment and dedication of management to have pride in the quality of services they provide. Quality necessitates good common

sense, financial stability, the ability to change, to be progressive, to be aware, and to have a management style that is concerned and sensitive to the needs of its staff. Most important of all, quality child care must value each family as a client totally satisfied with the services that provided.

The Day Nurseries Act has provided adequately to ensure the necessities of quality, but only the management of each center can provide the kind of quality that is so often disputed with regard to child care. It would be impossible for any form of legislation to address and monitor the issue of quality in its fullest meaning, as regulations alone do not determine quality.

Quality is an issue that will eventually come to rest. More and more parents are extremely knowledgeable and very selective about their child care. All styles of delivery -- government operated, non-profit and private enterprise -- will be forced to constantly reassess their programs and sufficiently satisfy parents or they will experience declining enrollment. The degree of excellence will eventually determine the success or failure of all centres.

Parental Choice: There are several questions to be answered regarding the child care field of the future, both near and distant. Perhaps the biggest question is, in what form will child care services take in the future?

We know that a large expansion in child care spaces is necessary. As the field expands, we want to provide the type of care necessary to the families and children of today to produce the solid citizens we need to carry our great country into the next century and beyond. Unfortunately, there is no consensus as to how this can be accomplished.

ADCO believes the only fair way to do this is to provide the parents of our children with wide alternatives in choosing the type of care they want for their children. This includes choices between structured and unstructured programs, academic and non-academic programs, programs offering different language training, musical and/or physical training, and choices between the different physical makeups and building types. It also includes the choice between government operated, non-profit and commercial centres.

Only by providing many different modes of delivery can we produce the highest quality of care. Those centres not providing what parents require would simply be forced to close their doors as enrolment faded. Universal government-funded child care could not provide this freedom of choice. We believe this will only produce a huge bureaucracy at a staggering cost and a bland, generic system of child care.

Commercial Versus For-Profit: The most glaring and misused term in the child care debate is "for-profit child care." This term would lead an outside observer to suppose that those people who operate centres as a business do so with the primary goal being the accumulation of profit. I am sure each and every one of you out there today could tell me of several different businesses that would be more profitable than child care.

In fact, the primary purpose of being in the business of providing child care is that we care about children, we care about our community and we care about the future of our society.

The secondary goal of our business is to provide ourselves and our family with a reasonable income and a pay-back of personal investment. The only difference between a commercial center and a non-profit is that we have followed entrepreneurial spirit which built this great country of ours. We have taken the personal risk of putting our past and future and our personal reputation on the line to provide a service which our fellow Canadians desperately want and need.

Profit Versus Surplus: The argument still remains that a commercial centre has the ability to make profit, whereas a non-profit centre does not have this ability. On the surface, this appears to be true. However, this argument fails to remain solid under closer scrutiny. Unless a non-profit centre is a charitable non-profit centre, there are still profits to be made and removed from the operation. Rather than being called "profits" they are termed "surplus."

Surplus may be removed in several ways depending on the structure of board of directors. First, if the board of directors is made up of private individuals such as husband, wife, child, accountant or lawyer, surplus may be removed by a salaried bonus at the end of the fiscal year. This is remarkably similar to an owner taking a dividend from the business. The only difference is that with a salary bonus, tax is only paid once on that money by the individual who receives the money in the form of income tax. A dividend is profit and therefore the business has already paid tax on it. As well, the individual receiving the dividend pays income tax on the amount taken.

Second, a board of directors can be made up of parents of children enrolled as well as interested citizens. Surplus may still be removed by an individual through two ways. These methods may also be employed by a private board of directors.

Firstly, an individual may take a lease on a property

which could be used for child care. Then a non-profit centre is set up with a parent board. The individual then sublets to the centre at an increased rental rate thereby removing surplus from the centre.

Secondly, an individual may set up a management company to handle the many day-to-day decisions and tasks of operating a centre. They could then set up a centre with a parent board and charge the centre for management services, once again removing surplus from the centre.

In both these scenarios moneys is more likely to be removed from the centre than reinvested in it. A commercial operator is more likely to reinvest this money either in the existing school or in new locations in order to regenerate more profit. This serves the community; the removal of surplus does not.

The mystical idea that non-profit centres, on the basis of their legal classification as "non-profit," do not make money and are therefore inherently better centres, is proven false. All of those things commercial operators have been accused of are easier to do when operating a non-profit centre.

Who Operates the centres - Present and Future?: There are a few ideas that everyone involved in child care can agree upon. However, everyone agrees that we need more licensed care. In fact, Ontario has determined that the number of licensed spaces should double. This means we need to create 100,000 more spaces. In an expansion of this size, it will be necessary to maintain the quality and integrity of the present system.

Ontario has the good fortune to have some of the most experienced and knowledgeable child care experts in the country. These include the commercial operators. We cannot afford to shut this expertise out from any expansion. To expect untrained, inexperienced individuals to provide 100,000 spaces is unrealistic.

Many commercial operators are ECE trained. They have progressed from being teachers to opening their own centres. In many cases, operators' families who have benefited from the experience of their parents are taking over and expanding. Surely these are the kinds of people we need to carry on our superior system.

Opening new centres costs money. The public purse has many hands reaching into it now. Is it large enough to provide the capital for this expansion? Commercial operators provide their own capital. No government funds are used when the commercial operator expands.

Commercial operators also put money back into the

system through taxes paid. In fact, one estimate is that taxes paid by the existing commercial centres provide almost half of the total money provided by the province for child care. Economically speaking, it is essential that the commercial operators continue to exist and expand in order to fund the system.

The Problem of Profiteers: Whenever there is a great demand for a product or service, there are those who will take advantage by providing poor service for a high price. This can happen and does happen in the provision of child care.

The Association of Day Care Operators of Ontario strongly condemns this practice. Legislating a particular sector out of existence will not solve the problem. We have shown how an unscrupulous individual can take advantage of a non-profit classification. Restrictive legislation tends to breed new ways of circumventing the rules rather than preventing abuse.

The only way to rid ourselves of profiteers is to allow all sectors of the child care community to expand. At present we have excellent legislation to ensure a minimum standard of care. As the system expands, we must continue to enforce these standards and then let the market decide who will remain in operation and who will not.

Parents, if they have a choice, will not leave their children in poor quality centres. Operators, whether commercial or non-profit, will constantly have to reassess their programs and sufficiently satisfy their parents or they will experience declining enrollment. The degree of excellence will eventually determine the success or failure of all centres. There will be no room and no support for profiteers.

Conclusion: Philosophical discussions are best left to the university classroom. When they do enter the public domain, we put great pressure on our legislatures since seldom can an answer be arrived at that will satisfy everyone or even a majority. Be that as it may, you are still faced with the arduous task of coming up with a set of recommendations at the conclusion of your work.

Historically speaking, it has always been the commercial sector that has been the first to perceive a need in the community and act to fulfill that need. We have always counted on the private sector to fill very important roles in our society.

The care of children has been no different. Drug companies, baby food producers, diaper manufacturers, pediatricians and children's dentists, all invaluable and integral parts in caring for children, have never been

criticized for operating as a business. Why, when child care is in such demand and the need is so great, should we cast a blind eye on our past and exclude the commercial sector.

In conclusion then, do not dwell on ideology, on rhetoric or on emotion. A strong case has been built for the continued existence and expansion of the commercial sector in the child care community. The past is a good teacher. Let us not forget our lessons.

Thank you, Mr. Chairman.

Mr. Chairman: The first questioner on my list is Mr. Cooke.

Mr. Cooke: Thank you, Mr. Chairman. Just a couple of questions. Mr. Smith, you gave an example of how you thought the non-profit sector could in fact be turned into a for-profit system. Do you have any examples of that where that has been done?

Mr. Smith: Mr. Cooke, personally I do not know of any schools that are run that way. However, it is common knowledge that this can be done, and as was pointed out in the SPR Report, which was a lead report prepared for the Special Committee on Child Care at the federal level, they talk a great deal about this masquerading effect if the commercial operators were forced to become non-profit.

Mr. Cooke: Well, I would agree if we just forced the commercial operators to become non-profit, the commercial owners may in fact try to do that. We would have to build in some other like community boards.

Mr. Smith: In fact, that may already be happening.

Mr. Cooke: What I would like to ask you is, is it not true that perhaps one of the reasons why we would not know whether the not-for-profit sector is doing that is because they, like you, do not have to even file profit and loss statements with the Ministry even though there is substantial amounts of government money that go into your sector as well as the not-for-profit sector?

Mr. Smith: Certainly that is not correct, Mr. Cooke. First of all, if a centre has a purchase of service agreement with the municipality, they are under contract to provide audited financial statements at the request of the municipality. As well, in the Day Nurseries Act, there is a provision that if the Minister wishes to look at the financial statements of a day care centre that he can request those.

Mr. Cooke: But there is not a practice of making

available and publishing the profit and loss statements of day care centres currently in Ontario?

Mr. Smith: As far as I know, there are very few public day care centres in Ontario and therefore publishing those financial statements I think is against the law. I am not an expert on that sort of thing; however, the information is there if government wish to come in and inspect.

Mr. Cooke: Would you object to an amendment to the Day Care Act similar to an amendment that we just passed to the Nursing Home Act that would require the annual submission of profit and loss statements and posting them in day care centres and making them available to the public?

Mr. Smith: Certainly most centres at this time in Metropolitan Toronto submit audited statements every year. As far as posting them publicly, quite frankly, I do not feel that that is the public's right to know how a centre is operated. However, I do not wish to speak for the association and if you would like an answer to that question, we can get back to you on it.

Mr. Cooke: Well, I would like you to get back on that. You might want to review Hansard and review just what you said. You really do not believe that the public has a right to know how your centres are operated?

Mr. Smith: Mr. Cooke, I would like to compare it to the posting of personal income tax forms. Should we put them on everybody's mail box so that people can come around and take a look?

Mr. Cooke: I do not think there is any analogy or any parallel whatsoever. Can you give me an idea of what the profit levels of your members are, not in terms of dollars but return on investment or some figure that we can get an idea of what kinds of profits are being made?

Mr. Smith: We, through discussions with our members, have ascertained that, on average, a commercial operator could get the same return on his original investment if he left the money in the bank.

Mr. Cooke: Bank rates have varied in the last number of months. When was that done? When was that survey done?

Mr. Smith: About ten months ago.

Mr. Cooke: So you could be talking in the neighbourhood of 10, 12, 13 per cent return on investment?

Mr. Chairman: I am not sure that is --

Mr. Cordiano: 7 or 8 per cent?

Mr. Smith: Metropolitan Toronto, on their budgets that need to be submitted, outline 10 per cent as a maximum profit. However, that is very rarely realized.

Mr. Cooke: Can you give me some idea of what the breakdown in terms of ownership is in your group but not in terms of chains and so forth, but background of the individuals. How many of your owners actually do come from an educational background as opposed, say, from a business background?

Mr. Smith: I do not have specific figures for you, Mr. Cooke; however, I can tell you that the majority of people have been involved with children in one way or another and are now operating centres.

Mr. Cooke: In your brief, you suggested a large number of your owners come from an Early Childhood Education background. Perhaps if you could get that information for us, I would be interested in seeing what kinds of backgrounds your membership do come from -- the owners of the various centres.

Mr. Chairman: Is that individually or are you asking for a percentage?

Mr. Cooke: I am just looking at a percentage, yes.

Mr. Smith: And when would you like to know that, Mr. Cooke?

Mr. Cooke: Well, our committee is going to be deliberating over the next three weeks on it.

Mr. Smith: I do not know whether I could get you those statistics within three weeks. It would necessitate contacting each and every operator to find out their background. That information is not included on an application form to our association.

Mr. Cooke: I just assumed that you might have the information some place since you made the statement in your brief.

Mr. Smith: Roughly, we consider about 60 per cent. Around 60 per cent with ECE background. And I would say that if you included those people with experience with young children, including teaching or psychology, then the percentage is raised dramatically.

Mr. Chairman: Do you want some water, Mr. Smith?

Mr. Smith: Yes, I have some, Mr. Chairman. I sent my

tongue out to be starched.

Those individuals with purely business backgrounds are few -- definitely very few.

Mr. Cooke: You indicate in your brief the same kind of argument that I always hear from nursing home operators about how you are putting up the risk and putting up the capital and so forth. Is it not really true that when you are looking at a system like child care or a system like nursing homes that the reality is that the people that are really paying for the capital are the users -- partly the government in this case and partly the individual users?

Mr. Cordiano: You can say that about anything.

Mr. Smith: I do not think I quite understand you. I do not think that is true, but perhaps you would like to explain yourself.

Mr. Cooke: Well, who pays the capital?

Mr. Smith: Who pays the capital? Capital is something that an individual earns, has in the bank, takes it out, takes a risk, invests it in the community. If his business goes bust, his capital is gone. He might as well have thrown it out the window. No, no one is paying for the capital; capital is earned.

Mr. Cooke: What I am suggesting is that when a bank knows your occupancy, when a bank knows the demand and knows the going rate, there is not a lot of risk.

Ms. Nowak: Excuse me, Mr. Cooke, can I answer that?

Mr. Chairman: That was not your original question. The original question was a question of capital. I think Mr. Smith has answered that.

Mr. Leluk: The young lady here would like to respond to that.

Ms. Nowak: You did say that to the banks there is no risk; did you say that?

Mr. Cooke: I am suggesting that you have got a guaranteed cash flow.

Ms. Nowak: Well, go to a bank and try to open a day care centre. Let me tell you, there are not too many bankers that give loans out to day care centres. If you want to give your house as the mortgage or if you want to borrow it from your family, you may be able to get some financing. But day cares are not a good risk nor are they quick to jump to finance day care centres.

Mr. Cooke: If the option is a non-profit centre, the capital would be generated for a non-profit centre in exactly the same way.

Mr. Smith: No, I am sorry; that is not true. You have to have a certain amount of capital to open a centre. You need start-up funds. Banks will not lend non-profit centres money because there is no one person accountable. This is what makes a commercial operator unique. They have the fortitude to stand up and say, "I will take that risk, and I will be responsible and I will pay back this loan personally if the business fails."

Mr. Chairman: Mr. Cooke, Mr. Jackson has a brief supplementary. Mr. Jackson?

Mr. Jackson: I was just going to comment that in this whole concept of risk, the banks are less willing to take risk when the public debate currently is on less government funding per child. And so I am saying that, even if this --

Mr. Chairman: Is that a supplementary answer or question, Mr. Jackson?

Mr. Jackson: It is a point of clarification for Mr. Smith's benefit.

Mr. Chairman: I think if Mr. Smith wants to nod agreement with that we can turn it into a supplementary, I guess.

Mr. Cooke: Mr. Chairman, the point is there is cash flow and a non-profit system would be able to set up. It might in fact be in the way that we have suggested for nursing homes. There might have to be some guarantees in terms of loans for non-profit centres. But if in fact the private sector currently is able to generate enough cash flow to expand as your members have, that from an organization that started off with all single day care centres and now is up to 50 per cent in smaller chains, then obviously there is something in the system for you and your fellow owners.

Ms. Nowak: Single centres.

Mr. Smith: I am sorry. I am not sure what you mean by "smaller chains."

Mr. Cooke: Smaller chains, whether it is more than one day care.

Mr. Smith: Oh, I see. If we link two things together, we get a small chain. Okay. Certainly there is a return. I mean, you would not be working unless you were

getting paid. I do not think that you would do this job for free. So there is a return, granted. There is a perceived need in the community; these people care about children, they take the risk, they set up the centres to provide the care to the children.

Mr. Cooke: Final question. Are you satisfied the comment you make in your brief is that you think we have a good system of accountability in terms of the regulations? Do you see any deficiencies at all in the regulations and how the inspectors carry out their duties in the reporting system that currently exists in the province?

Ms. Nowak: Yes, we do see a deficiency. The fact that any centre today is put into a category of being poor, we feel this is inexcusable today. We certainly would like to put pressure on our friend Mr. Sweeney that they need more help in the monitoring system. We do not want to see poor centres either in any sector.

Mr. Cooke: When you said they need more help with --

Ms. Nowak: I think that there is not enough consultants available. They need, where people are having problems or they see a poor centre, they need to do something about it. They need to either close them or -- In this day and age because there is such a shortage of spaces, you do not want to close a centre. But then help the centre. Give them the help, the resources that they need -- not financial resources, but program help or where they see a weakness in a centre.

Mr. Cooke: Do you think violators should be substantially fined?

Ms. Nowak: Fined? I do not know if they could afford very many fines. It is a thought but I do not --

Mr. Chairman: Mr. Cordiano?

Mr. Cordiano: Thank you, Mr. Smith, for coming before the committee and preparing that extensively thought-out brief.

I want to talk about the whole question of your position as stated, I believe, at the last press conference you had, whereby you said that ADCO and its members would not be willing to accept direct government grants if the government moves in that direction. Given that position, how would you foresee your industry's ability to overcome low salaries in the commercial sector? How could you overcome that and various other issues, but I will let you answer that one first.

Mr. Smith: Just to clarify, we did not say we would

not accept government grants. What we have said is we do not like government grants. As operators, we do not wish to receive the government grants. If the government wishes to grant money in order to increase salaries, then we suggest that money goes directly to the staff and never comes to the operator or the business.

However, in saying that, there are certain ways that could be worked out for this money to be directly funnelled from the government to the staff providing expert accountability. I will not go into that at the present time.

However, we feel that rather than a system of direct grants, what we need to do is increase the subsidy system and change the subsidy system in this province. And I realize that takes some cooperation with the federal government in changing the Canada Assistance Plan. And whatever Mr. Epp and his associate Ministers decide to do in the coming months will really tell the tale.

What we would like to see is a subsidization level raised to about \$30,000 per year income per family and that, on a diminishing scale, your fees would be subsidized accordingly.

So, for instance, if you made under \$20,000 you would be totally subsidized -- and these numbers are right off the top of my head -- if you made \$25,000, your fees might be 75 per cent subsidized, et cetera, up to about a maximum of \$30-, maybe \$35,000. Above that we see a system of tax credits to help out those people up to, again, another maximum level, whereupon after that all fees paid would be the responsibility of the parents.

Mr. Cordiano: Now, you have just addressed the whole question of affordability and moving to an income-testing method rather than a needs-testing method which is in place right now, and that is another issue.

But just to get back to this whole question, how do you, as a commercial operator, foresee increasing salaries over a period of time, because you do have a higher rate of turnover in your sector and one could point to that and say, well, obviously there is a dissatisfaction level there for the person who is a member of your staff who is not making as much money as someone who is working in the non-profit sector or a municipally-run public day care operation.

Mr. Smith: First of all, the reason for turnover of staff is not exclusively because of salary. In fact, a study done recently for the Day Care Advisory Committee of Metropolitan Toronto indicates that salary is actually low on the level of why staff leave the centre. In that study as well it indicates that there is very little difference,

in Metropolitan Toronto, very little difference in salaries between the average non-profit and the average commercial centre once you cut out government-operated centres because indeed they pay higher rates. So there are different reasons for turnover rather than salary. Salary is a part but not a large part.

Now, in order to pay higher salaries you need to increase your revenue, plainly and simply. We would like to be able to do this. However, increasing fees means that parents cannot afford your services. So what we are looking for is for the government to provide parents who cannot afford higher fees with some assistance.

Mr. Cordiano: Well, that, as I say, I think is a separate issue. The question of affordability and providing more service to the populace, that is something that obviously has to be addressed. But I am looking at the commercial sector and saying to myself, Well how are you going to address this question of low-paid staff, and how do you get their levels of salaries higher? As you have suggested you are willing to look at some form of government direct grants, but you would not want to handle it.

Mr. Smith: Not only that, but we do not feel that the government should be paying people's salary. Off hand, if we decide that people who work in convenience stores are too low paid, I do not think the government is going to start handing over money. What we need is to have these people be paid for the job they do at a reasonable rate, and those people who use the services, support those salaries. And I disagree with you that it is a separate issue. Affordability, staff salaries, expansion -- they are all intermixed. You cannot separate these as separate items, I am afraid.

Mr. Cordiano: So what you are suggesting is that if you are allowed to have a greater share of the market, which is what you are saying, because if we make day care more accessible and more affordable, then your sector will be able to expand and as a result of that expansion, you will have greater revenues? Is that what I am understanding?

Mr. Smith: No. First of all, we do not want a greater share of the market. We believe that there needs to be a mix of non-profit, government-operated and commercial centres.

Quite frankly, we feel the mix right now is pretty good. It is not too bad. By expanding, you do not get increased revenues. You increase the price you charge the public and that is how you increase the revenues. And then out of those increased revenues you pay higher staff salaries.

Mr. Chairman: Mr. Cordiano, I do not wish to cut you off, but we have two more questioners and we have allocated an hour for each of the groups. If you have another question, are brief question, then...

Mr. Cordiano: Well, I am just looking at this question of affordability and how that would translate into supposedly increased revenues for your operation in the commercial sector. Would you allocate that to increase salaries? Or if you have been in a position where you have not made great returns on your equity that you invested how are you going to translate that and turn it around and make the moneys available for salaries?

Mr. Smith: Nobody wants to make a great deal of money off of child care. Operators want to make a salary, a decent salary, to live on for them and their families and a return on their investment. Okay? So the commercial operators are not looking for an expansion of their profits. We do not need to make more profits. We do not want to make more profits. No one likes to pay their staff low salaries. Unfortunately, it is inherent in this field that salaries are a large chunk of the centre's income, and yet income is low so salaries must also be low. We would like to see revenues increase; therefore we can afford to pay higher salaries.

Mr. Cordiano: How do you increase revenues though? This is what I do not --

Ms. Nowak: I think you are misunderstanding. What he is saying is --

Mr. Cordiano: You are increasing the fees which then becomes a problem of affordability.

Ms. Nowak: Right. And that is what we are talking about, the subsidized system. For example, if we raised our fees \$30 per week, we would be able to pay our teachers good salaries. I am just taking a figure -- say, \$30.

Mr. Cordiano: Yes.

Ms. Nowak: However, half our parents would have to leave our schools because they cannot afford it then.

Mr. Cordiano: Right. This is why I am asking, how do you address the question of increasing salaries when you have this "catch 22" situation.

Ms. Nowak: We are saying that if the subsidy system was opened up to another level -- A lot of people are getting their day care free at the moment; right? But there is a lot of people that as soon as you put the fees up any higher, they are out of the ballpark. They have to leave

the system. That is why we are suggesting that to expand the system to include people who make up to \$35,000, that is where the help is needed also in addition to expanding the present system that we have.

Mr. Cordiano: Fine. Thank you.

Mr. Chairman: Thank you, Mr. Cordiano. Ms. Labelle?

Ms. Labelle: Just a few quick questions; back to the issue of quality. On page 3, you say that regulations alone do not determine quality. Does your association have any formal process for monitoring the quality in homes?

Mr. Smith: Of homes or centres?

Ms. Labelle: Of centres, rather.

Mr. Smith: No, I am sorry. At this time, we do not.

Ms. Labelle: Do you have any set of quality standards, quality assurance program, that you are contemplating other than what is specified today?

Mr. Smith: Yes, definitely. We have been discussing this for quite awhile. One of things we have been waiting for is our membership to increase. We do not want to scare off people by saying, "We are going to come in and check you out." Actually, what we are looking for is working with other various interest groups to form this inspecting or level-setting body.

Ms. Labelle: You think you might scare off your operators if --

Mr. Smith: No. "scare off" is a bad term. I kicked myself as soon as I said it. What I mean is that you do not want your neighbour coming into your house and telling you what is bad. Okay? So what we are looking for is trying to find an impartial body to do this.

Mr. Jackson: Can I have a supplementary on that?

Mr. Chairman: Supplementary, Mr. Jackson?

Mr. Jackson: I guess it is to the consultant. Are you referring to a form of self-regulation for the industry? Is that something you can give clarification on?

Ms. Labelle: Well, there are various forms of quality assurance programs that range all the way from self regulation to formal regulation, and I just wanted to know if anything of that sort existed or was administered routinely by the association.

Mr. Smith: Not at present.

Ms. Labelle: And I think the answer is, "No."

Mr. Jackson: And there is nothing under active consideration for a self-regulatory model?

Mr. Smith: Yes, we are considering some sort of system like that. We have been doing so for quite awhile. Next month we are meeting with an association that has set up some sort of self-governing body in the child care field, and we are going to be working closely with them to see if we can apply it to our association.

Mr. Jackson: My final on that supplementary point, Mr. Chairman, is have you had any dialogue with the government or the Ministry with respect to any discussions about a self-regulatory model?

Ms. Nowak: It is interesting that about six years ago we went to the government and we asked them if they would help us with that, that in addition to the regulations that were in place, would they help us develop a five-star system or some sort of additional regulation. The government said they not help us, that that was not their job.

Mr. Chairman: That is a secret that every counsel knows; you never ask a question that you do not know the answer to, Mr. Jackson.

Mr. Jackson: No; I am pleased to know.

Ms. Nowak: But we do think it is something for the future that would be, certainly, to the benefit of all, but certainly to have it that there could be some impartial bodies do an inspection other than government inspectors.

Mr. Smith: As a matter of fact, we were having discussions with a lower-level ministry official not too long ago.

Mr. Jackson: There are not many lower --

Mr. Smith: Well, lower level than you. This was discussed at the time and there may be some future work with the Ministry in child care services in the future.

Mr. Chairman: Ms. Labelle?

Ms. Labelle: You made quite a statement about the surplus and the potential uses for surplus. Do you have any information on the relative rates of profit in the commercial sector versus the rates of surplus making in the non-profit sector?

Mr. Smith: No, I am sorry; I have never --

Ms. Labelle: Do you know that surpluses do exist in the non-profit sector?

Mr. Smith: Yes.

Ms. Labelle: What evidence do you have of that?

Ms. Nowak: There is one thing I would like to clarify too, that not all non-profit centres have community boards, as it seems to be suggested over and over again. We are familiar with a number of non-profit child care centres that do not have community boards that have certainly indicated to us that they do have surplus.

Ms. Labelle: So you have no survey or any idea of the exact amount of surplus generated by these centres?

Ms. Nowak: No.

Ms. Labelle: Okay. Are wages lower in the commercial sector than they are in the not-for-profit sector for similar types of work?

Mr. Smith: On the average?

Ms. Labelle: On the average.

Mr. Smith: Slightly.

Ms. Labelle: Do you have a percentage maybe that you could --

Mr. Smith: If you want facts and figures, I suggest you contact Metro Children's Service. There was a survey done for the Day Care Advisory Committee of Metro Toronto and that outlines quite clearly about a lot of things -- staff turnover, salaries, that kind of thing.

Ms. Labelle: We were just asking if you were in agreement with that. Wages are lower. Okay. One final thing; you are relying on parents to judge the quality of centres? You say if the quality is not acceptable, parents will react by pulling their children out of centres. Are parents able to judge the quality of care given in a day nursery?

Mr. Smith: Yes, I think so. Every parent probably is looking for something slightly different. Each parent brings up their child in a slightly different way and wants slightly different things for their children. So for each parent there is going to be a different standard of quality. If the centre does not meet that parent's standard of quality then they will remove their child.

Ms. Labelle: The question is, do you think that parents are able to assess that?

Mr. Smith: Definitely. Definitely.

Ms. Labelle: And what are the implications of having very few spaces available? We heard before that there is a long waiting list and excess demand.

Mr. Smith: If there are very few spaces available, then we do not afford the parents this choice. They either use the informal market or they take what they can get. Saying that, however, there are still parents who will be very selective about the care that their child receives and will still pull children out of the centres and will even have a spouse stay home to look after that child rather than leave him or her in poor quality centres.

Ms. Labelle: Is that a viable option for most of your clients?

Mr. Smith: No, not all of them.

Mr. Chairman: Mr. Baetz? I might add as well for the benefit of the committee, Mr. Jackson has requested a copy of that report. We are going to attempt, through the clerk, to get a copy of that as well as a copy of the Day Nurseries Act for your benefit. Mr. Baetz?

Mr. Baetz: Yes, Mr. Chairman, the delegation that preceeded you, the Social Planning Council of Toronto, made the point that the more people that are served by for-profit organizations -- your group -- the greater will be the government's reliance on the commercial sector to achieve social policy objectives. In other words, you will be setting the policies governing day care.

At the time I disputed that. Some of the things that you have said here made me wonder a little bit whether, in fact, you see the private for-profit day care operators in Ontario sort of the last stronghold of the bastion of private, fierce, free enterprise. And that statements like, "It is really nobody's business how much profit you make here" or some of the other comments that are all in Hansard by this time, it really makes me wonder -- and this is a rather general question -- but do you not believe that if you, as the private operators are going to have a place, an official place in the whole spectrum of day care services in this province and that directly or indirectly there will be an infusion of public money into your operations, that in fact there will be more regulations -- a lot more regulations. As sure as night follows day, this always happens. To what extent can you brook this kind of intervention? To what extent can you see it as appropriate?

Or will you say, "Well, to hell with it; we are going to walk away from the scene."?

Mr. Smith: Sir, I do not pretend to speak for every commercial operator; however, the industry now is very highly regulated as we know. Ontario has probably the highest standards and the highest regulations for child care in North America. So be that as it may, the operators are still very proud to say that they are entrepreneurs; they support free enterprise and they are free enterprisers.

I do not think that reasonable regulation, more regulation, would upset operators. I do not think, certainly as far as the quality of care, regulations that govern the quality of care, we are not opposed to and never have been opposed to, despite what other people might tell you. And I suggest that is a misreading of the deputation we presented to the Standing Committee on Social Development in September, 1984, and I am sure that is on records if you wish to read it. We did not ask for a cutting down in quality or a diminishing of regulations. We support strong regulation so that no person or firm or board can abuse the child care system in Ontario.

Mr. Baetz: And you fully anticipated that there will be --

Mr. Smith: Certainly. If there is more government money unfused into the system, the taxpayers in this province have a right to know what is happening with it. We respect that.

Mr. Baetz: That is somewhat different from what you had stated a earlier on. But anyway, I will accept that as the final --

Mr. Smith: I think it is under different circumstances here. I am not sure that it is necessary to pin somebody's financial statements outside their door for everyone to come and take a look at. However, the public of Ontario respect their elected representatives and rely on them to make laws for them all the time. Why should they not rely on them to judge whether a centre is doing a good job or a bad job with government's money? Being public knowledge and being inspected and regulated by the government are two different things I think.

Mr. Baetz: Thank you.

Mr. Chairman: Further questions? Thank you very much. We appreciate your brief. It was very thoughtful.

Mr. Smith: There are a few typos.

Mr. Chairman: That is all right. You should read

some of my memos, notes.

Mr. Smith: Mr. Chairman, in closing, if there is anything else that our association can do for your committee during its deliberations, please feel free to contact us and we will do our utmost to provide you with any information.

Mr. Chairman: The next delegation is Happy Child Nursery Schools Ltd. Mr. Hunt and Brenda Donoghue as well? Is Ms. Donoghue here? And Catherine Hunt.

I would only ask you to speak into the microphone so that we do pick it up for Hansard. Perhaps, Mr. Hunt, you would like to introduce the presenters and who is going to --

Mr. Hunt: My name is Frank Hunt. We originally opened up Happy Child Nursery Schools in 1957. We are the old-timers in the business. My wife, Catherine. My daughter Brenda Donoghue. She currently operates our centres for us. We have other interests because it is not a high-profit business so we are involved in other businesses as well.

Mr. Chairman: Just before you start, Mr. Hunt, there is no printed brief?

Mr. Hunt: No, we do not have one, unfortunately. We just made some brief notes in point form to address the difference between private and public day care. I suppose that is what this committee is all about.

So we looked at ourselves and took a look at the public day care which is available right now -- or the regional day care -- and found out some interesting comparisons between the two.

Mr. Chairman: Could you help us so we can understand; where is your day care centre?

Mr. Hunt: They are both in Mississauga. This is our fifth and sixth day care nursery since 1957. We wrote the grounds, you might say, on initiating day cares into the communities. We went up against zoning boards. We are a small family-oriented business and it is in the second generation now.

We do have long-term commitments on leases for our current buildings; therefore, we are quite interested in what happens. We think we have done a great job over the years. We have always made it a policy of keeping our prices low for the sake of the parents and to provide the best care possible.

To this end, myself personally, I went and took the

TNEA course at Walmer Road Institute of Child Study, which was kind of unique; I guess I was the only guy in there. And I felt that if we were going to operate day nurseries, we had to know as much or more than the teachers did.

So we initiated our business on that basis and, of course, I must admit I am a free enterprise advocate. I feel that the private sector can do anything better than the public sector. I may be prejudiced but I think if you look around the world and you look at the way privatization is going on in England and the way things operate in Russia, I think our system has got to be a lot better. So we have always operated on that basis.

Now, this morning I phoned around to see where we stood. Now, the average '85 wages of a man and a woman in Canada, according to StatsCan, the total family income was \$47,605. So these people that would not qualify for subsidy under our present systems or anything down the line. That is where our main source of clientele come from.

So we checked out the local municipal day care system, which is operated by Peel, to find out just what this couple would pay for a three year old at that level, and they told me that their per diem cost is \$21.70 a day, which means that their weekly rate would cost them \$108.50.

Now, we are currently charging \$87 for the same age group. And granted we are paying our staff a little less than the municipal people are, but we feel we have an excellent group of staff. And we feel they are very dedicated particularly in view of the fact that they are making less money. They have got to be dedicated because they are not in it for the money.

The difference, approximately \$10 a week, roughly, if we were to bring our wages up to meet the scale that they are paying -- We did some research and found out the difference between their wages and ours and that would be what it would cost us. So we would have to charge our parents \$97 to provide the same salary as the municipal people are for their three people, because they require three people for a group of 24 three year olds. That is the ratio: 1:8.

Now, an interesting thing I came across, in paying \$108.50, the lowest subsidy -- Let us say there is a -- Now, I went on one end of the stick which was the couple who made the average for Canada, and then I went and asked them, "How much would it cost if you were a single parent and had no visible sources of income?" They said that you would have to pay \$3.58 a day.

And if you look at the difference between the \$3.58 they expect the parent to pay and what they want to charge

the guy who has the income, you see that they are being subsidized to the tune of \$18.12 per diem -- that is per day. Now, we are also in the subsidy program and we have contracts with them. The maximum they pay us is \$9.10.

So it seems that to get a subsidy space in a private nursery like ours, the government levels are paying us \$9.10 for subsidy, and the parents are paying the rest, that in the public sponsored one, which is non-profit, so to say, \$18.12 a day.

Now, either we are awfully well managed or they are badly managed; I do not know which. But if we had that difference, \$10 per diem, we would have an extra \$50 a week, and there is not that much difference, unfortunately. That would be for one child.

So anyway, a lot of figures are confusing, I suppose. The disparity in the wages is about \$2.33 an hour between what we pay and what they pay. Now, how we get around that I do not know, because most of our parents are at that limit where they have to pay their own way. If they cannot, they can apply for subsidy if they do not qualify.

Therefore, to get our standards of wages up in line, which I cannot really relate to -- I cannot really relate wages and quality. I have heard this rap and I am, frankly, not convinced that just because you pay a guy too much money or more money or double the money, he is going to do a better job for you. He has to be dedicated to start with, and you have to have a good management system and you have to have a good deal of expectations for that person to carry out. And you have to have the experience to know whether he is doing it or not.

So, in looking down the line, we looked at the way you can get around this. Now, the average family that is getting paid 47,605 a year -- by the way, that was '85 Stats Can; that is the latest one that is out -- if you took it at 4 per cent a year over the last year, that would be up to fifty-one five.

I do not know what percentage of the total population this might represent because it does not tell you. It is just the median point so I assume there is just as many above as there is below; I do not know. Maybe there is three times as many earning three times as much and one guy less; I do not know. But perhaps you could fathom that out. I do not know how StatsCan comes to that determination or where the people in that field get their figures from in relationship to subsidy that they pay out.

Tax deductions are based on \$2,000 per child per year and, of course, you are only saving the taxes on that. It seems to me that if you allowed the whole shot for the day

care fees it would be a little more realistic in subsidizing the parents who are paying those fees. Even if they are in the high income brackets, it would be fairer across the board.

The incentives that you might be able to come up with for students so that they would enter the ECE field would be of great advantage to us. We have a dreadful time right now getting the staff we want. In our particular centre, we have ECE-trained people in each of the classes who are responsible for the overall program, and they are assisted by what we call "assistants" and they have varying degrees of ECE training. Some partial -- say they are drop-outs -- some have foreign training where they have not upgraded to meet the standards here so they can quality as ECE's. But we get a variety of people who assist.

It is not ideal and we are trying to -- if you say, "compete" -- with the municipal type of quality care, then we would have to pay, as I said, that extra \$2.33 an hour for those three people.

I do not know if direct grants to us would be the correct way to go. We do not seem to have any answers any more than you do as to how you deal with it. We just feel that from what we have heard on the Journal, on TV and in the papers, we private operators who have tried to do a good job over all these years are getting a bad name over it, and we feel our reputation would not have lasted thirty years if we had not done it right.

We are not tarred with the same brush, fortunately. There are some bad operators out there just like there are some bad mechanics, I suppose, in garages, and there are good ones.

I do not know whether payment and the rate of payment has anything much to do with it either, if I can equate the two. It is a pretty difficult equation. But, we just thought we would like to come done mainly to get information and then they sprung it on us that we were going to be asked to speak to you. So we thought we would just say our little peace. Although it is very down to earth and based on what we have to deal with everyday as our budgetary costs and the way we operate our business, we would like to tell you that we are not a high-powered business. We did not get into it for profit and I think our retained earnings over a 30-year period came to \$48,000. We are looking at a pretty low earnings rate of less than \$1500 a year; I guess about \$1500 a year for 30 years ago.

Mr. Baetz: Mr. Chairman, would you just repeat that figure? What was it?

Mr. Hunt: \$48,000.

Mr. Baetz: For 20 years?

Mr. Hunt: Thirty years.

Mr. Baetz: Thirty years.

Mr. Hunt: It is not too great, is it? Inflation and all, you know.

Ms. Donoghue: I think a point that has to be made as well, we are constantly dealing with the quotes of poor-quality day care in the private sector. All the people in day care, whether private, non-profit or regional, are governed by the Ministry of Community and Social Services, are program advisors -- people that we go to to get advice for programming, staff problems, and meeting all of the regulations in our Day Nurseries Act.

If there is poor quality day care, I think, instead of it reflecting on the private day care operator, it should be reflecting on the people in the Ministry who are not doing their jobs. I am not saying that they are perfect; maybe there is a lack of -- But I certainly know of centres as well out there that should not be operating. I am not proud to be associated with them or along with them and I feel that some direction has to be made that the Ministry must be lacking if there are poor quality centres out there. There is no excuse for it; we are all governed by the same rules and regulations. However, the private day care operator is doing it with less funds.

Mr. Chairman: Are you a member of that organization - ADCO?

Mr. Hunt: No.

Mr. Chairman: Mr. Cooke?

Mr. Cooke: Just so I can get a better idea of how your centres operate --

Mr. Chairman: Sorry, Mr. Baetz; were you finished?

Mr. Baetz: Yes. I just wanted to interject.

Mr. Cooke: I was just wondering, the three of you work for the centre or the centres?

Mr. Hunt: Yes.

Mr. Cooke: So that it is fair to say -- and I am not being critical in any way -- that in addition to the very minimal return on investment, you would be able to draw salaries? And the only other area would be if you owned any

of the assets, there would be the equity that is in the facilities.

Ms. Hunt: That is right. I think we already stated too that we are in another business besides day care because it is not high profit. I mean, we could not have lived for 30 years on \$48,000. This is what we are trying to get across, that this is always the argument.

Mr. Cooke: No, no. But I mean, you are able to draw salaries and you live on the salaries. Yes. Well, you do not live on the profits; you would live on the salaries.

The number of Early Childhood Education staff that you have, the staff that are graduates from the community college system?

Ms. Donoghue: I am sorry; what was the beginning? How many?

Mr. Cooke: How many of the staff are graduates from the community colleges?

Ms. Donoghue: Well, we have at least one in every centre. If you have four, three-year olds for 24 children we are required to have two early childhood educators and an assistant teacher, being someone that is in training. We have early childhood educators in every single room of those centres. We have people, instead of having the two in our groups of 24, we have people with one year experience or one year completion and are completing it at night school because we cannot get the ECE's required for the second -- They consider a group size to be 16; anything over and above 16 you require a second ECE.

Mr. Cooke: What would your ECE people be getting paid?

Ms. Donoghue: Approximately \$13,650; that is their annual salary.

Mr. Cooke: And the municipal salaries in your area get --

Ms. Donoghue: -- \$16,410.

Mr. Cooke: Both miserably paid.

Ms. Donoghue: Right.

Mr. Baetz: What is your turnover?

Ms. Donoghue: Our turnover I do not think you can state is always because of the poor income. We are in a transient society. We are a field that mainly employs

women; we have had one male in the last ten years. And they follow their husbands, they are getting pregnant, they are leaving. We do have a high turnover.

Mr. Baetz: How does it compare to municipal day care centre turnover?

Ms. Donoghue: To be honest with you, that is not something that I am aware of. I do not know. I know a few girls in the region that have just recently left because they just had babies, but I have had the same situation. I do not know statistics.

Mr. Chairman: Mr. Cooke?

Mr. Cooke: No, I am fine. Thank you.

Mr. Chairman: Any further questions? Mr. Cordiano?

Mr. Cordiano: Just very briefly, we talked about the possibility of -- I asked this twice before today but I would like to ask you as well -- to get your opinion of this whole question of low wages in the commercial sector. Do you see a possibility of your being able to handle or would you accept something in the form of a direct grant from the government? Would you accept that and would you be able to work that into your operation if the government moves in that direction?

Ms. Donoghue: Yes.

Mr. Hunt: I believe the way the directive is going from what I gather, you would like to give a grant to the school to turn right directly into wages. I would say that would be great because then our girls would get paid what they are actually worth.

Ms. Donoghue: And even then perhaps not.

Ms. Hunt: And it would be an incentive to students to go into the field, which is not happening right now.

Mr. Cordiano: So do you think that would be some encouragement to people who are looking at ECE as a career, that would provide some incentive?

Ms. Donoghue: Yes, definitely. I think the statement by Jeff Smith and I know part of what they are looking at, pushing for, is that it go directly towards the teacher and not go through the centre itself. I believe that the reason for that is because there is so much talk that we are into such a profit-making business that we would take the funds.

I just think that would completely eliminate -- if it was to go directly to the workers, to the teachers

themselves, then there is no one who can come back to us and say, "Well, what have you done with those funds?" and turn them around. But we would be open to whatever means would allow the staff to have a higher wage.

Mr. Cordiano: So you would not be averse to the possibility of greater accountability as a result of that?

Ms. Donoghue: We already are accountable, and that is true. It is stated in the Day --

Mr. Cordiano: I mean in the financial sense because of the direct grants.

Ms. Donoghue: Yes. We already are though. Anyone can at any time walk in and ask to look at our financial books, and that is a fact. Not to say that it happens, unless it is someone in the Tax Department or something like that; they may want to for auditing. But we are. It is stated right in the Day Nurseries Act; it is a requirement by us already to be licensed.

Mr. Cordiano: You also mentioned the fact that the Ministry -- perhaps there is a problem with Ministry consultants. Do you feel that they are not qualified enough to deal with some of the problems?

Ms. Donoghue: I do not know if it is a lack of qualifications as opposed to -- I know that their caseloads are far too heavy. There is a lack of program advisors around.

Mr. Cordiano: So there is just not enough day care?

Ms. Donoghue: They are carrying 115 centres for one person. Even if she was to visit every centre, that gives her less than two and-a-half times a year that she can visit each centre. And if there is a problem in a centre which requires more time, it is very hard for them to monitor them properly. But certainly there is a lack of them and there is a lack of support by them. It is very hard to get in touch with someone in the Ministry if you want because they are out on the road all the time.

Mr. Cordiano: So you would like to see those services increased too?

Ms. Donoghue: Most definitely. We have nothing to hide. I feel if there is poor quality day care out there, something has to be done about it. I am all for that. I want them to walk into my door every day.

Mr. Cordiano: These consultants or Ministry people are working with you as well as with various over types of not-for-profit day care operators?

Ms. Donoghue: Uh-huh.

Mr. Cordiano: And so they are spread right across the entire province dealing with all day care operators?

Ms. Donoghue: Uh-huh.

Mr. Cordiano: So you think that that would increase the quality --

Ms. Donoghue: Certainly.

Mr. Cordiano: -- that would enhance your ability to provide better quality service?

Ms. Donoghue: I think probably the lack of day care space that you are hearing about all the time, that there is not enough care, is probably a reflection why a lot of these poor quality day cares are still operating because the Ministry does not want to shut them down because there is other people on the other end screaming, "We do not have enough spaces. How can you shut the centre down?"

I do not know how you resolve that situation but it certainly, I believe, it does happen that there are centres --

Mr. Cordiano: Well, I am trying to address the question of quality and improving support services to your operation as well as not-for-profit and publicly-run operations in the form of consultative services and other kinds of services to improve quality and programming for the various centres. And those centres that are not operating at a higher quality level or one that is acceptable, obviously you are suggesting that if there were more consultants available, after addressing some of these other issues, would there be a possibility that they will increase their quality. Or do you think that these people who are operating these bad centres are just bad operators and have to be thrown out of the business?

Ms. Donoghue: I do not know. I mean I do not know if I am the one who can make a judgment on that. I feel if they are meeting the requirements of the Day Nurseries Act they should not be operating, period. Because the laws are there for a very good reason. We all back them; we all agree with them. And I think anyone who is operating under the Day Nurseries Act and running a good business is proud of it. I think those that are not do need to be shut down. Or perhaps they need assistance and I do not know what that would entail.

If the government is considering putting money into the child care field, perhaps that is where some of the

money could be concentrated on, is helping those centres. Maybe closing them down and opening them up and continuing on the business; I do not know how you go about that.

Mr. Cordiano: Well, that is another issue be resolved.

Ms. Donoghue: Yes.

Mr. Hunt: Or a warning that would give them time to get back in line and then help them do it.

Mr. Cordiano: What I am saying is that for those operators that are providing a good quality service, you do not foresee a problem in the sense that moneys are targeted, for example, to salaries. Then you are going to have an increased ability to offer salaries that are commensurate with the kind of work that people are doing and to lift those salaries up to the level of the public-operated day care centres.

Mr. Hunt: It would make it better, when we do lose a good girl who has worked with us for years, in trying to entice people out there to our nursery. We are at a disadvantage at the present time because we have to offer less. Therefore, the ones who are looking for the higher money end up going to the one who has the most of it. It does not necessarily make them the best, but at least it gives us a wider range of people that we can look at when we are determining which one will do the best job for us.

Mr. Cordiano: Thank you.

Mr. Baetz: Mr. Chairman, just two quickies here. You say you do not belong to ADCO?

Mr. Hunt: No.

Mr. Baetz: Did you at one time belong to AIDCO? They were the independent operators.

Mr. Hunt: We stayed independent. We keep our --

Mr. Baetz: Why do not you?

Ms. Donoghue: I am considering it.

Mr. Baetz: You are considering it. You have nothing against ADCO; it is just that you are sort of --

Ms. Hunt: No, no. Absolutely not. I think they are doing a good job. That is not the reason.

Mr. Baetz: What are their membership fees?

Ms. Donoghue: I do not know; that is what I have to find out.

Mr. Baetz: You have to find that out.

Ms. Donoghue: That is right. It is not very much.

Mr. Baetz: Who among you is full time in this business?

Ms. Donoghue: I am.

Mr. Baetz: And the others are --

Mr. Hunt: -- part time.

Mr. Baetz: Okay. Just to comment on the supplementary on the previous question on the -- I think a lot of it is attitude -- is it not? -- of the operator? In order to make a buck, a big buck, you are going to be --

Mr. Hunt: -- disappointed.

Mr. Baetz: Basically why you are in it?

Ms. Donoghue: We are there for the kids.

Mr. Baetz: I just want to say, Mr. Chairman, I appreciated the presentation here -- refreshing, grass root.

Mr. Chairman: It is very nice to have you here and I just wanted to ask you a couple of questions. What is the total number of children? You have five --

Mr. Hunt: Hunt.

Ms. Donoghue: No. We have two at the present time. We did have five. We had five, but we sold four of them, continued operating one in Mississauga, and two years ago expanded and opened a second. So at this present time we have two, and we have 160 children approximately between the two centres -- 165.

Mr. Chairman: Now when you say you sold three -- did you say? -- or four?

Ms. Donoghue: Four.

Mr. Chairman: Were they sold as going concerns?

Ms. Hunt: They were all fully involved at the time. The main reason for our selling them was because we did get involved in another business, and we just could not spread ourselves thin enough to look after them all to make sure they were being run properly. And then when Brenda decided

to get into the business on a full-time basis, this is when we considered opening a second one again. That is no explanation of why we had five and went down.

Mr. Chairman: One hundred and sixty children between the two of them. Would they be about equally split between the two centres?

Ms. Donoghue: We have 86 licensed in one and 75 in the other.

Mr. Chairman: Do you operate that out of leased accommodation?

Ms. Donoghue: Yes, we do. And the children range in age from three months to five years.

Mr. Chairman: Are they full time during the day?

Ms. Donoghue: Yes; full, five days a week.

Mr. Chairman: So you have 86 children, three to five --

Ms. Donoghue: Three months to five years.

Mr. Chairman: You deserve an award for sanctity, I would think. Just one final question, if I could. In terms of the saleability of those ones that you sold, were they readily saleable?

Mr. Hunt: Yes. At that time we ran into an operator in Toronto here who was trying to expand and he bought one. We sold one to a supervisor who worked for us, gave her the option of buying it, and we sold the other one to a supervisor of ours who still operates it.

Mr. Baetz: In the same family tradition?

Mr. Hunt: Well, yes; she is carrying on.

Mr. Chairman: When you do sell them in that vein, is there some transfer, licence transfer, of these children?

Mr. Hunt: No. She has to apply for her own.

Mr. Chairman: She applies for it; it is re-approved?

Mr. Hunt: Yes. You cannot sell a licence.

Mr. Chairman: Okay. And we had a point made here that a for-profit person who goes out to start to create a day care centre has difficulty in getting money just on the basis of the business getting started up; do you concur with that?

Mr. Hunt: With us, when we expanded, of course, we had a base on which to work so they looked at our sources of income from our existing businesses when we went to expand and our track record of course, just like they would any other business.

Mr. Chairman: When you opened your first one?

Mr. Hunt: That was terrible. Three mortgages, bank loans, everything you can think of. At that time -- that was a long time; that was '57 -- we used to pick the kids up from 7 o'clock in the mornig and drop them off up until 6 o'clock at night. We supplied transportation ourselves in our own station wagons or school buses and we charged \$12.50 a week.

Mr. Chairman: Within your present neighbourhood or area that you serve, are there a number of other for-profit day care centres?

Mr. Hunt: Oh, yes.

Ms. Donoghue: Quite a number.

Mr. Chairman: Do you have any idea of how yours stacks up in terms of people attending it as compared to the others?

Ms. Donoghue: We have waiting lists at both centres. We are proud of our centres; they do have good reputations in the area, but we also know that other centres are full as well. I do not know about their waiting list, to be honest with you.

Mr. Chairman: Do you have any idea how their rates compare with yours?

Ms. Donoghue: Yes; we are in the middle. We are not the lowest; we are not the highest. I would say that it would be -- Well, we are 87. It would be from 85 perhaps to 92, would be the range.

Mr. Chairman: And just finally, if I could, from your experience over the years in day care centres, when a parent comes to enroll their child, would you say that they were more often, less often or middle of the road in terms of the quality versus the cost or the location?

Ms. Donoghue: The clientele that we deal with, I believe, are more -- I would say, yes, they are very interested in quality because there are a number to choose from in the area and we do cater to the middle class families. And they take their time; they do a lot of looking and then come back. We also recommend that they do

that because we do not want a parent enrolling a child in our centre that is not feeling very comfortable about the service they are going to be getting. We have an open door policy; they can come at any time to view the premises.

Mr. Chairman: Those are my questions. Are there any questions from the committee arising out of that? Roberta, I think you indicated you had no questions?

Thank you very much, Mr. and Mrs. Hunt and Ms. Donoghue. We appreciate your coming forward. It is very interesting to hear from you.

Ms. Donoghue: Thank you.

Mr. Chairman: We have a few items -- committee, do not put your jackets on yet -- that we have to discuss. One of the more -- I should not say "more important" because they are all important -- but the first one I would like to deal with is Mr. Cooke's. And then we would deal with -- The second item I chose to deal with is the question of a vice chairman. For some reason we did not select one.

Mr. Cooke: Mr. Chairman, if I might, I am concerned that what we have got here is a schedule for the next few weeks that is relatively light actually. But more important than that is that we are dealing with the issue of child care. Decisions are being made by the federal government and the provincial government now. And as I understand it policy announcements by this government are going to be made in May; yet the way that we planned our agenda, we will not be writing a report that deals with any of this until some time in late summer or early fall.

Mr. Cordiano: Sorry; could you repeat that? You said the government will not be making any policy announcements until May?

Mr. Cooke: I said they are making policy decisions. So what I am suggesting is that what we should do is rearrange our schedule so that people that currently are scheduled in the last week, which is the week of April 6th. And if you look there is Monday afternoon that is filled, there is a bit on Tuesday that is filled and a bit on Thursday morning that is filled and then on April 9th.

So if we rescheduled those for next week and even possibly running over into the Monday of the last week, we could take the Tuesday, Wednesday, and Thursday or whatever amount of the time we required -- I am not sure that we would require an entire full three days -- but we would have the opportunity to write an interim report that could be tabled, and we could, I think, have some input or at least make use of the fact that policy decisions are being made now by the government and have some input into that policy.

Otherwise, basically in terms of child care itself, other than the impact on the final report on the whole issue of privatization and commercialization, many of these deputations that are being made now are not particularly worthwhile. I am not suggesting that they are not helpful in terms of helping all of the committee members understand the issue of child care, but I am suggesting that the expectation from the people that are making presentations is that this committee is actually going to have some input before the government makes all the decisions on child care policy.

So I would, for the purposes of discussion, simply move that the schedule be rearranged so that the final week of the committee leaves us three days to write an interim report for the legislature on the issue of child care.

Mr. Cordiano: Mr. Chairman, I have not fully looked at the agenda -- and I do not know if we can do that given the -- Perhaps we should turn it over to the clerk and ask the clerk whether in fact these groups have indicated that they will be coming on those particular days and what problems that might pose in terms of scheduling.

Clerk of the Committee: Well, I can indicate that we know definitely that one person who is scheduled to appear on April 9th, Renee Edward, can only appear on that day. That is the only day that she can fit it into her schedule.

There are other groups that we have tried to schedule earlier -- move them up into this week or next, and it is not possible and we may run into problems there in terms of rescheduling.

Mr. Cordiano: I would be hesitant, Mr. Cooke, to do that, given that reason.

Mr. Chairman: I wonder before -- just a second, Mr. Cooke. Before we get into this, I was under the impression and I certainly would bow to Mr. Cooke's longevity in the legislature, but it is my understanding that our terms of reference allow us to prepare an interim report overall, which we have done -- I believe it is 295 pages -- is that right? -- 236 pages, and a final report.

Now, Mr. Cooke indicates, and I will bow to anybody else who perhaps has greater information on that that we can do it, but it is certainly within the terms of our standing order that we prepare an interim report and a final report on the overall ball of wax. I understand your reasons, Mr. Cooke for wanting to do an interim-interim report, but I would also think that we would have so get through the 236-page report, draft report, to get it filed with the legislature as our interim report before we ever talk about

an interim-interim report.

Mr. Cooke: Well, Mr. Chairman, I think if one looks at select committees and I think actually --

Mr. Chairman: Is that a cigarette that I see?

Mr. Cooke: Is this a no-smoking committee?

Mr. Chairman: This is a non-smoking committee.

Mr. Baetz: When did you quit?

Mr. Cooke: Mr. Baetz probably has had more experience with committees than I have. I have not been on that many committees that have written reports, but I have dealt with committees making interim reports, as a member of the legislature that attends all the House leaders' meetings. And all one has to do is take a look at the economic committee and take a look at the number of interim reports that it filed.

Another good example would be the Energy committee that has filed over the years its previous form. And the current Energy committee, they file reports. The fact is that, sure, we want to accommodate the people that have made presentations but we want to also make their presentations meaningful. And if all of the policy decisions are made on child care before this committee reports, then it is not a terribly meaningful process.

Mr. Cordiano: I think that is a matter of interpretation. It is your view that the fact that the government is deliberating on this, in fact that has been taking place for some time now.

Mr. Cooke: Public statements have been made by the Minister. It is clear that there is going to be a report because Mr. Sweeney has said there is going to be decisions made. There was a statement made in June.

Mr. Cordiano: That is right, but obviously that should not impede our progress here. That should not hinder it in any way or that should not get in the way of what we do here. I think that what we do here has to obviously reflect hearing the people that come before the committee, giving them an opportunity to have their say. I do not think we are going to accomplish that unless we stick with the agenda, unless we are going to exclude these people. I do not see how you get around that problem.

Mr. Leluk: Is that input going to be taken into consideration in the development of government policy in the report that is coming up or are we just going through an exercise here?

Mr. Chairman: Hold on now; Hansard is going to have an Excedrine headache pretty soon if we all talk at the same time.

Mr. Cordiano: I think that the Minister has clearly indicated he is aware that we are obviously meeting; he has indicated that he would like to see a report from this committee.

Mr. Leluk: What is the point of getting the input if it is going to have no bearing on the government report? You are just going through an exercise.

Mr. Cordiano: Mr. Leluk, you are agreeing with Mr. Cooke?

Mr. Leluk: Well, I am making my own comments here in relationship to why this committee is in fact sitting. If you hear from different groups involved in the day care program here in this province, then surely this input should be put into the form of a report and given to the Minister responsible for Community and Social Services and then that should be taken into consideration in formulating the government report.

Mr. Cordiano: That is exactly what we intend to do, Mr. Leluk.

Mr. Chairman: Mr. Baetz was the only one who has raised his hand. I think I am losing control of this meeting somehow. Mr. Baetz you had a --

Mr. Baetz: Yes. Thank you, Mr. Chairman. Mr. Chairman, I, as you know or as you may recall, I expressed the same concern that has been expressed by Mr. Cooke and my colleague Mr. Leluk. I expressed this about three or four weeks ago when I first heard and saw the announcement by the Minister and really wondered whether in fact government policy was away ahead of this committee. And if so -- and nobody can stop that, I guess -- and if so what really was the value of our committee and what would be the value of the delegations coming in here and expressing their views.

So I do not know what the precise mechanics are about how we get an interim report in, but I would support Mr. Cooke's proposal that one way or another we try to get at least some interim report on record before government makes its policy statement or makes a decision or whatever. So I would support Mr. Cooke's proposal.

Mr. Chairman: Then we can address the issue but I do not know whether it is today or not. I do not know --

Mr. Cooke: The thing is, the longer you leave it,

then --

Mr. Cordiano: Well the clerk has already indicated that there is certainly a number of people who would not be able to come at any other than stated.

Mr. Cooke: We are not exactly under a lot of scheduling pressures.

Mr. Chairman: I am sorry. I apologise. I misunderstood the clerk. If the committee agrees to do it, we can do it. But the clerk is not sure how we would get it into the House. As you know, we have authority to file the interim report during the non-sitting of the legislature and we can also file it in the House because there is authority for it. I do not know how we file an interim-interim report. I do not know how the Energy committee does it or how any of the others --

Mr. Cooke: The same way they file every other report.

Mr. Cordiano: Well, I am taking the direction of the clerk, Mr. Cooke.

Mr. Chairman: If we want to agree here that there be an interim-interim report and that the staff prepare it and we take the chance that it may not be acceptable and may be not be technically receivable in the House because it is not part of the terms of reference --

But I caution you as well that the first objective, the first thing that we were charged with, was getting the interim report into the House. We are already behind time in doing that. I would suggest that we address that first.

Mr. Leluk: Mr. Chairman, I was not a member of the committee dealing with that first interim report. Was day care specifically part of that interim report?

Mr. Chairman: Basically, Mr. Leluk, it was facts and figures and accumulation of data. It is a data report more specifically.

Mr. Cooke: I suggest then, Mr. Chairman, that all my motion says is that the last week of the committee be rescheduled so that we have a couple of days to write a report on the issue of child care.

If you look at the last week, we could continue our hearings on the Monday. If you wanted to, we could even continue them on the Tuesday morning, which would still give us Tuesday afternoon, Wednesday and Thursday. And that would require the clerk to contact the groups that were scheduled for the latter part of the week and ask them to come in at the beginning of the week or next week, whichever

is convenient to them.

Mr. Chairman: Well, Mr. Cooke, if you are going to move that motion could I ask that we -- we have a lot of time between now and then -- that we consider the interim report and let us get that finalized and filed so that we have done well.

Mr. Cooke: Of course.

Mr. Cordiano: I still would like to raise the issue that you have to contact -- I think it is possibly nine or ten groups and rearrange the... Is that what you are suggesting, Mr. Cooke? Because I do not quite follow.

Mr. Chairman: You are saying at the end of the --

Mr. Cooke: My motion is saying you can leave Monday, April 6th, the way it is. You can take a look at April 7th and there are three groups. On April 8th there are two groups and on April 9th there are three groups. You can take the Wednesday and Thursday and ask the Wednesday and Thursday people to see if any of them can come next week and give them the option of next week or the Tuesday, April 7th. That will give us the Wednesday and Thursday to write a report.

Mr. Cordiano: Right. I already asked the clerk earlier if any of these people would be able to come or indeed if there are any that will have difficulty changing their time slot.

Mr. Cooke: We already heard that.

Mr. Cordiano: Well, that is what she said. She said that they would have a great deal of difficulty coming on any other day. I mean, that is fairly straight forward. Can I ask the clerk again to repeat that.

Mr. Baetz: One had difficulty.

Clerk of the Committee: Yes. We know definitely that Renee Edwards, who is scheduled for April 9th, cannot attend at any other time.

Mr. Cordiano: Now, would there be any others on that list that you might have difficulty contacting first of all? And secondly, that you might be aware of that would not be able to come at any other time, and therefore would be excluded from this process?

Mr. Chairman: Mr. Cooke, I wonder if you would be content that you put motion -- that it remain tabled and let the clerk, between now and tomorrow, determine whether that is possible.

Mr. Cooke: If that is what the committee decides, that is what I will go along with, but the fact of the matter is I think we have to give the clerk direction, and I think we have to make the decision this afternoon. Because even if there was one person that could not attend I would still prefer that we were actually making the presentations of the people that can attend meaningful and allow us to write a report. Otherwise I think all you are doing -- which may seem appropriate to you but it does not seem appropriate to me -- to just have public hearings for the sake of having public hearings.

Mr. Cordiano: Well, it is not appropriate to me to exclude anybody from coming before this committee.

Mr. Leluk: What is the point of their coming here if you are not going to get any input into government policy?

Mr. Cordiano: Sure they are going to have input. That is the whole point of having committee hearings.

Mr. Leluk: The policy is announced in advance of the report going in. What input is there?

Mr. Chairman: Well, just a second. I think what Mr. Cordiano is saying is if we cannot rearrange --

Mr. Leluk: Let's not talk nonsense.

Mr. Chairman: Just a second. -- if we cannot rearrange the groups to begin before we do that interim report then, in fact, we are cutting them out. So that is why I am suggesting that we give the clerks the opportunity to determine whether or not the last week of this particular hearing for this issue can be cleared up between now and tomorrow and we can then vote on your motion.

If we vote on it now, you know exactly what is going to happen, Mr. Cooke. We are going to be asked, I would think, for time to gather members; that is going to take twenty minutes. I would think that would be the case, and I would certainly grant it in accordance with standing rules. But why do we not let them do it and find out whether we can do and let us achieve the end I think we are all trying to achieve.

Mr. Cordiano: I do not have any problem with achieving the same end.

Mr. Baetz: As long as we recognize that we are supporting Mr. Cooke's motion.

Mr. Cordiano: Sure. I do not have any problem doing that if you do not exclude anyone.

Mr. Cooke: What I would like -- just because I think that there should be a decision made so that we do not continue to drag it on and make the rescheduling even more difficult -- that we decide when we are going to vote on the motion. Tomorrow afternoon at two? Tomorrow morning at ten? I do not want to leave it until Wednesday.

Mr. Chairman: Okay. Let us go on to the second item. What I was going to suggest was, for the consideration of committee, would be that tomorrow -- if you look at your agenda, there are three presenters -- there is nothing in the afternoon and yet the following day, which is the Wednesday, it is suggested that we consider the interim report.

What I would like to do, if the committee is in agreement, would be to try to compress these a little rather than just use day after day, half days and then what do we have? We have little enough time for this entire procedure as it is.

I would suggest that we put on it in the afternoon a start of the consideration of the interim report if that is possible. And at the same time that we set 2 o'clock in the afternoon as the time for dealing with your motion. That will give the clerk sufficient time in the morning to get ahold of these people and determine whether or not they are available. Is that agreeable?

Mr. Cooke: That is fine.

Mr. Chairman: And what I would suggest as well is that perhaps, if this is a 236-page document, that we are probably going to, depending on how much is at issue, we are probably going to require an additional day, and I suggest again that we do not let days disappear. Would the committee be content with us meeting on Wednesday as well to continue the consideration of that report and then play it by ear as to whether we set Thursday?

Mr. Cooke: That is fine but most of this report is what we went through already.

Mr. Chairman: We may be able to complete it tomorrow. If we can, fine; so be it. But if we cannot, I would like to --

Mr. Cooke: We did go into it fairly thoroughly.

Mr. Chairman: Now, we have a couple of other items and I am sorry to keep you. Now we have a request for expenses from three groups; one has asked for mileage from Kitchener and return. Any difficulty with that with the committee? It is Providers and Children Together

Association. It is a single individual, Mary Ann Wasilka.

Mr. Leluk: What do we base the mileage on?

Mr. Chairman: 26 cents per kilometre.

Mr. Leluk: 26 cents per kilometre?

Mr. Chairman: Any difficulty with that? Do we have a consensus from the Committee to that?

The second one is CUPE, Local 2204, Day Care Local. They would like to send someone with light travel expenses paid; and they are located where? In Ottawa. As you recall, we set aside a week to travel. We may not have to travel because there does not appear to be anybody who wishes to see us outside of Toronto.

Mr. Baetz: It sounds like a good deal if we can pay their way here.

Mr. Cooke: How many are there?

Mr. Chairman: We were suggesting one person.

Mr. Cordiano: That is fair enough.

Mr. Chairman: Do we need a motion for that?

Clerk of the Committee: Can we do them all at once?

Mr. Chairman: All right. We will do them all at once. The next one is Ruth Rose Lise, University of Montreal, a former member of the Katy Cooke Task Force. We are looking at expenses and possibly overnight accommodation.

Mr. Leluk: Are we looking at other provinces here or strictly provincial groups or individuals? I am just concerned; she is at the University of Montreal?

Mr. Chairman: Yes. Are any of these looking for expert fees?

Ms. Deller: I do not think so. She may be believe.

Mr. Chairman: We have no indication as to whether she is looking for expert fees, but that is --

Mr. Leluk: I think that that should be determined in advance, Mr. Chairman. Secondly, I think we have to make a decision as a committee whether we want to be funding travel expenses for people from outside the province.

Mr. Baetz: The other consideration, Mr. Chairman, is

the Katy Cooke report is going to be out -- when is it out? It is out now, is it?

Mr. Chairman: Can we perhaps vote on the first two and then I will have the clerk check into the question of whether there are fees being requested as an expert and then we can consider that tomorrow. Those in favour of the expenses for the -- Sorry; we need somebody to move it. It is moved. Moved by Mr. Cooke; those in favour of the expenses for one and two? Carried.

And item three will be deferred until the staff has had an opportunity to determine that -- the clerk, I should say.

There is a young lady by the name of Carol Howes who is a reporter with the Calgary Herald. She originally approached me to do an interview. I said, "No" simply because I do not feel that as chairman I should be expressing and using this committee without simple concurrence from the other members. That may be politically naive, but I think that is fair in advance of us hearing the witnesses. She would like to meet with a representative from each party and the chairman. Can we agree on that?

Mr. Cooke: I am already meeting with her.

Mr. Chairman: Well, that is fine, Mr. Cooke.

Mr. Cooke: No. I mean, I do not think you should feel, as chairman, reluctant at all to do interviews as a chairman of the committee. You are entitled to do that.

Mr. Baetz: -- that is your problem.

Mr. Cooke: You are entitled to do that.

Mr. Chairman: You have arranged then for your own meeting? All right. We will do the same thing.

Now, the election of a vice chairman is of some importance and I have a bit of a problem there.

Mr. Cordiano: Do you want to do that tomorrow?

Mr. Leluk: Let's just defer that.

Mr. Chairman: It may be critical because I may have difficulty getting here until 11:30, 12 o'clock tomorrow. I believe it is the same party, is it not?

Mr. Cooke: It could be anybody. You obviously have somebody in mind.

Mr. Chairman: Well, I asked Mr. Henderson and he has

declined. Would anybody have difficulty with Mr. Cordiano?

Mr. Baetz: We will have great difficulty but we will support it.

Mr. Cordiano: I would prefer not to, but --

Mr. Baetz: Oh, now; come on.

Mr. Cordiano: -- since all my friends are here today I think --

Mr. Cooke: Why do you not just have one of your colleagues chair the meeting?

Mr. Cordiano: You do not have to have a vice chairman.

Mr. Chairman: And we have been asked about clippings and what the committee is going to do next after --

Ms. Fooks: I was just wondering if the committee wanted press clippings, and I presume you want summaries of briefs?

Mr. Cooke: Yes.

Mr. Cordiano: Are you going to compile data?

Mr. Chairman: There is one very critical question. I would like to find out how much of the hearings we would like to have Roberta here at. Obviously if we are going to be doing the report, we need Roberta here for the report.

Ms. Labelle: Can I just say something before you go? A few weeks ago we had asked that the steering committee be approached about how much of the hearings the consultants were wanted at. We did not hear back. In the absence of any reaction, we assumed that the answer was zero, so we have had to schedule other things.

I am going to try to make it to as many as you think necessary, but it is going to be very difficult at this point for us to attend beyond today. How is that?

Mr. Chairman: Well, I think that probably answers our question.

The Committee adjourned at 5:05 p.m.

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SELECT COMMITTEE ON HEALTH

COMMERCIALIZATION OF HEALTH AND SOCIAL SERVICES:
CHILD CARE

TUESDAY, MARCH 24, 1987

Morning Sitting

SELECT COMMITTEE ON HEALTH

CHAIRMAN: Callahan, R. V. (Brampton L)

Andrewes, P. W. (Lincoln PC)

Baetz, R. C. (Ottawa West PC)

Cooke, D. S. (Windsor-Riverside NDP)

Cordiano, J. (Downsview L)

Hart, C. E. (York East L)

Henderson, D. J. (Humber L)

Johnston, R. F. (Scarborough West NDP)

Reycraft, D. R. (Middlesex L)

Stephenson, B. M. (York Mills PC)

Turner, J. M. (Peterborough PC)

Substitutions:

Jackson, C. (Burlington South PC) for Mr. Andrewes

Leluk, N. G. (York West PC) for Mr. Turner

Mitchell, R. C. (Carleton PC) for Miss Stephenson

Clerk: Deller, D.

Clerk pro tem: Manikel, T.

Staff:

Fooks, C., Research Officer, Legislative Research Service

Witnesses:

From Playworks Day School Inc.:

Zelikovitz, J., Owner and Director

Individual Presentation:

Friendly, M., Research Associate, Centre for Urban and Community Studies,
University of Toronto

From the Ministry of Health:

Hart, C. E., Parliamentary Assistant to the Minister of Health
(York East L)

From the Providers and Children Together Association:

Wasilka, M. A., Acting President

Bleackley, C., Fund Raiser

LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON HEALTH

Tuesday, March 24, 1987

The committee met at 10:05 a.m. in room 2.

COMMERCIALIZATION OF HEALTH & SOCIAL SERVICES:
DAY CARE (continued)

The Acting Chairperson (Ms. Hart): Well, I guess we should...

Mr. Cooke: Could I just raise one point?

The Acting Chairperson: Yes.

Mr. Cooke: My colleague, Mr. Johnston, phoned me this morning. He arrived as you did, last night I guess, from Nicaragua and had to go pick up his son and will be here this afternoon and wondered whether the final discussion and vote on the motion of writing the report in the third week could be, instead of decided at two, decided at three when he knew for sure that he could be back for that.

Mr. Cordiano: Can I speak to that?

The Acting Chairperson: Yes.

Mr. Cordiano: I do not think there would be any problem, Mr. Cooke, with delaying it until three or whenever you like. There is no problem for our party.

Mr. Cooke: Okay, thanks.

The Acting Chairperson: Do I have a consensus on this?

Agreed.

Mr. Cooke: Thanks.

The Acting Chairperson: Our first group today is Playworks Pre-Schools. Mr. Zelikovitz, would you like to come forward and take a seat.

Mr. Zelikovitz, if you would like to introduce yourself for the record and then make a presentation, please proceed.

Mr. Zelikovitz: Okay. My name is Joel Zelikovitz. I am the owner and director of Playworks Pre-Schools, two day care centres in Toronto, one is in East York and one is in the City of Toronto.

I have an E.C.E. degree and a B.A. from Western. The commercialization of child care can, in my opinion, along with all types of child care, be to the benefit of the child care delivery system. Due to the ever present large demand of licensed child care and the short supply of spaces, I feel, with the proper checks and balances, there is room for the commercial sector.

As an early child care educator, I welcome government guidelines in the child care delivery system. These guidelines ensure all programs are providing quality and high caliber care.

I am a private day care owner. I started my centres from an idea my wife and I had and we have worked exceedingly hard without any government grants or support to make them successful. I chose this profession because I am interested in early childhood education. I want to work in and run centres where children could flourish and where I could influence an innovative curriculum.

When I began my business I felt good about the project I was embarking on. I felt I was fulfilling a much needed public service by providing quality affordable care to working parents. Both of my centres have purchase of service agreements with Metro and thus adhere to Metro's more stringent standards.

I am successful because I run two excellent centres which promote abundant opportunities to stimulate a child's mind and body within a cognitive oriented pre-school curriculum. I am successful because the children are happy. I am successful because the parents are happy and until recently I have been happy because I helped the economy by starting a small business and providing a service to families.

We, in the private sector, responded to the needs of the community by setting up child care facilities. We have provided quality and needed services for many years.

One problem I see is that day care advocates and some politicians have a goal of reducing commercial centres. They have not provided us with research saying that our programs are inferior, that children in our centres are not flourishing, or that parents are not happy, only that day care should be a social service and not a commercial service.

The negative aspects of a universal publicly-funded day care system such as; the costs to the taxpayer, the cost at the time of deficit budgets, the dissatisfaction of difficulty existing in public-run institutions, the uniformity of a government-run child care system, to me,

seem to far outweigh the positive factors of workplace centres, locally-run day cares in church basements, the fiscal responsibility of a private centre, ethnic-oriented centres and, ultimately, the whole spectrum of choice for the day care consumers.

I like what I do, the parents of the children in my centres like what I do and the twenty-three staff whom I employ as an independent like what I do. I want to continue as a private day care operator and I think that in order to provide diversity and security in the day care field, it is vital that the needs of private day care operators be considered. Any changes that take place within the child care delivery system must strive to include private centres in positive ways.

The Acting Chairperson: Thank you.

Any members of the committee have questions? Yes?

Mr. Mitchell: Yesterday the Social Planning Council of Toronto, one of their recommendations was that there be a grant system set up which at the end of three years would be lost to the for-profit operator, that at that time it was suggested that the for-profit centres would become basically not-for-profit operations.

You as obviously an independent businessman, I think, are capable of answering the question. How would you react to a situation like that? Say, would you be prepared to continue as a not-for-profit, or would you close your doors or would you seek selling out of your facilities too?

Mr. Zelikovitz: I would really have to understand as to what all the implications were to change it to a non-profit. I can tell you that if one sector, the non-profit sector, was the sector to only get grants or if they were cut off after three years, if I did not change it to non-profit, I would have to close my doors in order to stay in business. The factor of change...

Mr. Mitchell: I am sorry, you missed me on that. You would have to close your doors to stay in business?

Mr. Zelikovitz: No. I would have to close my doors so I would not go into debt.

Mr. Mitchell: All right. You see what I am coming from is: Do you think you could still provide the service and charge the fee that it would cost you without any government support at all?

Mr. Zelikovitz: Say that again.

Mr. Mitchell: Would you continue to be able to

operate by charging what the cost would be to you to provide that service assuming that you would have lost any provincial funding?

Mr. Zelikovitz: No, not if non-profit centres are getting a lot of -- I would lose all my teachers basically. I would not be able to afford -- most of my costs are in my salaries. The grants that most of the commercial centres are getting would be going almost directly to hiring staff. A teacher coming looking at my centre, looking at what I am paying my staff, there is no way I could compete with a non-profit centre getting grants. The only way I could compete would be to raise my prices in order to...

Mr. Mitchell: Well, that is the point I am making now. Your clientele, would they be able to afford...

Mr. Zelikovitz: My clientele, no. My clientele is the same clientele as all day care centre clientele.

Mr. Mitchell: So effectively what you are telling me is if that were to come about you would to have to close your doors?

Mr. Zelikovitz: Or turn into a non-profit so I would be eligible for those grants.

Mr. Mitchell: And how do you feel about that whole issue of turning into non-profit?

Mr. Zelikovitz: Not very good. I feel very negative about it and basically I would be losing my business, I would be losing my equity, I would be losing my company, so I do not feel very good about that.

Mr. Mitchell: Thank you.

Mr. Baetz: Madame Chairman, can I ask a supplementary to that?

The Acting Chairperson: Yes.

Mr. Baetz: What percentage of your residents -- is that the right word we want to use?

Mr. Zelikovitz: Sure.

Mr. Baetz: What percentage are now subsidized and what percentage are on their own?

Mr. Zelikovitz: In one school at Yonge and St. Clair it is 50/50. The other school which is a new school, it is in Bennington Heights in Willowdale, probably a more affluent area, it has about a 20 per cent subsidy, but what is happening is the subsidy numbers are constantly

increasing. As soon as there is a vacancy, because I have a Metro service, they are always calling me out of their spots and I get a quicker response from the government or from the City who is always looking for a spot rather than from the private sector who may take their time or, as an individual, you know, they just do not have the access.

Mr. Baetz: But then assuming that there would be an enriched plan of child care tax credits that would go directly to the young parents or that there would be enrichments in other ways for child care given to parents, do you think that you would have enough clients to continue in that case? I mean then they would have their choice, they can either send them to your school or they can send them to a...

Mr. Zelikovitz: I do not think so. I take a basic premise that child care centres are licensed, they have to meet a certain criteria so there is a certain basic quality of centre. Why should they pay more to send them to my centre than another centre down the street.

To me it does not make sense. I get a lot of calls right now, you know, they do not care about the program at all, you know, it is: How much, how much, how much, you know. Like, well why don't you come in and take a look. No, how much.

So I think the money issue is really -- you know, I guess it depends what the tax credit would be. If it is a total tax credit, I guess cost is no problem to the parent, but from what I have heard I do not think it would ever be something like that. So there is always going to be a discrepancy.

The Acting Chairperson: Have you finished?

Mr. Mitchell: Yes.

The Acting Chairperson: Mr. Cooke?

Mr. Cooke: Thank you. Maybe you said but I did not pick it up, the number of children in each of your centres.

Mr. Zelikovitz: I did not say.

Mr. Cooke: Okay. How many children in each of your centres?

Mr. Zelikovitz: 65 children at Yonge and St. Clair, licensed capacity, and 32 at the other.

Mr. Cooke: How many early childhood education graduates would you have on staff?

Mr. Zelikovitz: On staff, altogether?

Mr. Cooke: At each of the centres?

Mr. Zelikovitz: Okay. At the smaller centre our present enrollment is 24. I have two E.C.E. grads and two assistants, and at the other site where there is 65 children I have six E.C.E. grads in five rooms. Under the provincial act there has to be one E.C.E. teacher in every room and I meet that criteria.

And I have a few other teachers who are assistants as taking the E.C.E. courses either halfway through or something like that. The people that I hire are interested in early childhood education. If they do not have any background, formal education then they have had really good experience, but we meet the provincial licensing requirements of the E.C.E. in each room.

Mr. Cooke: What kind of wage rates?

Mr. Zelikovitz: I am sorry?

Mr. Cooke: The wage rates for your staff?

Mr. Zelikovitz: The wage rates, they equal the wage rates that are average to the field.

Mr. Cooke: I am not sure what that is.

Mr. Zelikovitz: That would be anywhere from twelve thousand to sixteen thousand.

Mr. Cooke: And what are the wage rates then in your facilities?

Mr. Zelikovitz: Well, last year...

Mr. Jackson: Matter of order Madame Chairman. Is that within the scope of the committee, to be looking at the financial operations and...

Mr. Zelikovitz: It is all public information.

Mr. Jackson: I appreciate that. My reason for raising it is if that is within the scope of the committee then we are at liberty to proceed in this general area with all deputants. I just wanted to know if that was -- it had not been explained to me. This is only my second day on committee.

The Acting Chairperson: Well, this is my first ever as Chairman.

Mr. Baetz: We talked about pay scales yesterday, so I

guess we are entitled to talk about it today and tomorrow and the next day.

Mr. Jackson: I see. I just wanted the Chair's ruling on the matter, if we are going to go into benefits and then pay and the compensation factor.

The Acting Chairperson: It occurs to me that we are talking about privatization and one of the issues that has been raised is that under public ownership wage rates are better, it seems to me.

Mr. Jackson: Very good. Thank you.

Mr. Cooke: Could I get an idea then of the wage rates of the graduates of E.C.E. in your program in your system?

Mr. Zelikovitz: Sure. Last year the graduates were starting at fourteen thousand.

Mr. Cooke: And the assistants?

Mr. Zelikovitz: It really depends upon their experience. They are a wide range from whatever they -- how far they are in their programs to length of time in service, et cetera.

Mr. Cooke: What is the turnover in staff? The one centre is a newer centre, I take it?

Mr. Zelikovitz: Right.

Mr. Cooke: The other centre has been in operation for how long?

Mr. Zelikovitz: Since June of '84.

Mr. Cooke: So this would be the third year?

Mr. Zelikovitz: Right.

Mr. Cooke: What kind of turnover in staff do you experience?

Mr. Zelikovitz: We have had a turnover in staff. I do not know. In what relative terms do you want me to tell you?

Mr. Cooke: I mean is it...

Mr. Zelikovitz: Well, as far as day care is concerned, I probably have the same turnover rate that everyone in the field has; Metro centres, co-op centres. You know, it is difficult work. I have teachers who were there almost from the beginning I have teachers who are

newer, you know, so it is...

Mr. Cooke: You state in here -- and I do not represent a riding in Metro Toronto so that is why I am going to ask this -- that you have to adhere to Metro's more stringent standards.

Mr. Zelikovitz: Right, as compared to the provincial standards.

Mr. Cooke: I do not want you to go through all of the differences, but can you just give me an idea of what the differences are?

Mr. Zelikovitz: Sure. They really touch into all different areas.

The province does not have any type of standards, or they have very basic standards as far as toy requirements; the number of tricycles per children in the centre and, whereas Metro, for a purchase of service agreement, go and their inspectors come out and look specifically for those types of things, the type of equipment that you have, you know, really look at the puzzles; are all the pieces really in the puzzles, are all of the bikes working.

So maybe that was more of a feeling that I had about the Metro criteria, although they do have stricter things as far as medication is concerned. Where the province says we can administer any type of drug that a parent brings in as long as they sign for it, whereas the City says no, you cannot do that, you can only administer drugs that are in a prescribed bottle or with a prescription. So, you know, in those types of different areas they are stricter.

Mr. Cooke: They have their own inspectors for Metro Toronto?

Mr. Zelikovitz: They have their own inspectors, right.

Mr. Cooke: Can you give me an indication -- the newer centre has been open for how long?

Mr. Zelikovitz: Since September of '86.

Mr. Cooke: The centre that has been open for a longer period of time, can you give me an indication of what kinds of profit levels we are talking about?

Mr. Zelikovitz: Well, I do not know if I feel comfortable saying that, not as a matter of hiding anything, but I think as a private businessman I do not think that is really too much of anyone's concern.

Mr. Cooke: We are told that you have to supply that information to the Minister.

Mr. Zelikovitz: Yes, right.

Mr. Cooke: So you would have an objection then to an amendment to the Day Nurseries Act similar to the one that was passed recently for the Nursing Home Act that would force owners of nursing homes to annually submit and allowed to be posted in their nursing home and available through the Legislature...

Mr. Zelikovitz: I do not really know how I feel about it. I would have to really look closely at something like that. I would not feel comfortable giving you my opinion right now.

Mr. Cooke: But you and your wife are making enough on your centres to make a living?

Mr. Zelikovitz: Starting to. You know, we have not made anything in the last two years and I had to basically take quite a loan out, et cetera, but we have been coming back slowly and my wife has another job as well.

Mr. Cooke: Do you own your buildings that the centres are in?

Mr. Zelikovitz: No. One is in a public school, one is in an East York Board of Education public school and we rent out space from them and actually to get that space I had to do a presentation and compete with 20 other schools; non-profit, profit, all kinds of centres and they picked us. And the other school is renting space on top of a retail store on Yonge Street.

Mr. Cooke: Thanks very much.

The Acting Chairperson: Mr. Cordiano?

Mr. Cordiano: Thank you, Madame Chairman.

Thank you for coming today. I just want to touch on a couple of issues. Would you agree that, with respect to your operation, wages and salaries paid to your employees, are they lower, generally speaking, than say a not-for-profit operator?

Mr. Zelikovitz: Well, I sit on the advisory committee for Metro Toronto and they have done a lot of studies and what the studies have shown is that there is a really large difference between a Metro centre and a...

Mr. Cordiano: That is a publicly-run, municipally-run centre?

Mr. Zelikovitz: That is a publicly-run, municipal centre, right.

Mr. Cordiano: Yes.

Mr. Zelikovitz: In between that and commercial and non-profit there is about a three to \$4 thousand gap.

Mr. Cordiano: Right.

Mr. Zelikovitz: And between a regular commercial and a regular non-profit, studies have shown that there is a slight difference. It is about five - well, from my recollection there is about five or \$600 a year difference between a commercial and a non-profit. Some people may feel that is a lot, some people may feel that is just a fraction. I do not know.

Mr. Cordiano: Okay. The whole question of salaries is largely -- when people talk about quality, they always point to the fact that the people that are employed by the private operators are usually or generally their pay is lower than in a not-for-profit centre or a municipally-run centre.

Mr. Zelikovitz: I do not think that is true. I think you can find instances of that, but I do not think that is, you know, a given. I know from experience that is not. I know of other centres that are paying -- non-profit that are paying less.

So maybe on an average there might be a slight difference but I do not think it is anything that is, you know, sort of real detrimental to the commercial side's point of view.

Mr. Cordiano: Now, if the government were to move to have direct grants for things like improvement in wages and salaries...

Mr. Zelikovitz: Right.

Mr. Cordiano: Would you feel adversely affected by that or would you welcome that?

Mr. Zelikovitz: I would welcome that. You see the costs are based -- the costs to the parents is what is paying the salaries, I mean, in essence so if you want to pay your teachers more it has got to come from someplace, so the costs -- the fees are going to go up.

No, I do not have any adverse reaction to a grant coming in. As a matter of fact what I would like to see is what the City of Toronto does. The City of Toronto does that right now. They give grants to non-profit centres.

The money does not go to commercial centres, so it is non-profit, but still there is a governing board. It does not go through that body at all, it goes right to the employee, right on their T-4 or whatever happens.

Mr. Cordiano: So you would like to see it go right to the employee?

Mr. Zelikovitz: Yes. I do not want to deal with that. I do not want the administrative problem of it either, sure. You raise the fees or you raise their salaries, you are going to get a higher quality of person, you are going to get a more dedicated staff, less turnover. It is great.

Mr. Cordiano: You are still the employer though. This is -- you are still the employer so you are going to -- the employee is going to receive this direct grant, it is a question of how you would administer it and you are saying you would rather not administer it, you would rather not handle any moneys that the government is directing towards your operations?

Mr. Zelikovitz: Well, only because commercial day care has really had a bad name throughout the last little while and I feel that if the money was directed to me as an owner, I mean, there go the advocacy groups saying again: Well, what are you doing with this grant and how much are you really giving to your employees. And I am really tired of that. I am a nice guy and I do not, you know, do things like that. Why should I have to deal with that.

You are right, I would benefit as the owner/operator, the quality of service would be better, but who is benefiting. The parents are benefiting, the teachers are benefitting, the children are benefitting. It is not even touching the profit picture at all.

Mr. Cordiano: So that would go hand in hand with your view about making your statements public, your financial statements public? I mean, you would not want that kind of interference by the public, you would not want that kind of scrutiny in terms of what your profit margin might be, et cetera. And as a result, you would not want to have direct grants from the government so that scrutiny -- you would be open to scrutiny if that were the case?

Mr. Zelikovitz: I am basically open to scrutiny.

Mr. Cordiano: Is that my understanding?

Mr. Zelikovitz: Well, I am basically open to scrutiny right now anyways. I have a purchase of service agreement with the City so I have to give them an audited statement every year anyway, so I do not know. It is there.

Mr. Cordiano: No, but I am referring back to what my colleague Mr. Cooke pointed out or asked you: If, in fact, you would make your financial documents available to the public for scrutiny by all?

Mr. Zelikovitz: I would rather not. It is my business.

The Acting Chairperson: A supplementary on that.

Mr. Mitchell: But in fact they are open to public scrutiny, the only thing is that the people have to go to the licensing operation in Toronto to get that information. Is that right?

Mr. Zelikovitz: I have never heard of that. You would know much more than I do.

Mr. Mitchell: But you do have to provide that because of the purchase of service?

Mr. Zelikovitz: Right.

Mr. Mitchell: Okay, thank you.

Mr. Cooke: We have not been able to get them, it appears.

Mr. Mitchell: No. Okay.

Mr. Cordiano: They are available to municipalities for their scrutiny.

I am finished, thank you.

The Acting Chairperson: Mr. Jackson?

Mr. Jackson: Thank you.

I want to refer to a couple of comments you made in your report. You talked about in the third paragraph:

"... I welcome government guidelines in the child care delivery system."

And basically you are talking about program here?

Mr. Zelikovitz: No, I am talking -- well, in essence program. I have my provincial director who comes in and inspects the centre. You know, I have a Day Nurseries Act and it is filled with all the rules and regulations of what I have to provide.

The provincial consultant will come in and she will give her suggestions as to programming and she will give

suggestions as to curriculum and she will give suggestions as to types of equipment. So on that aspect, you know, I welcome it. I think that centres -- I mean, there is a licensing criteria and centres who do not meet that criteria, you know, should be made to. So I welcome that from another centre.

Mr. Jackson: You make a very interesting point. Right from day one in these committee hearings we have been romancing this analogy between the Nursing Homes Bill and the Day Nurseries Act and one of the very strong and cogent arguments put forward by the Ontario Nursing Home Association was that the role of the inspector should be more like a consultant.

(Mr. Callahan resumes Chair)

Mr. Jackson: In essence it sort of played down the adversarial nature of the Inspection and Enforcement branch of the Ministry of Health. You use the word consultant but you started by using the word inspector and that is what I want to key in on.

Mr. Zelikovitz: Yeah.

Mr. Jackson: Therefore, I sense in this debate we are being pushed more towards an adversarial type system with accountability and more focus on staff salaries than children's programs. That concerns me because the best programs that I have in my area are all provided by the -- well, the public sector day care cannot compete with the private sector because of the quality program. They just say, we cannot provide the same kinds of program. So this is the net element of this inquiry that fascinates me the most.

Are you concerned that we might move in these guidelines for delivery system more to an inspection enforcement, shut-down, remove your license type of approach rather than program enhancement, consultation and direction for improvement?

Mr. Zelikovitz: Do I see a push for one side or the other? I do not see a difference. I think there needs to be both. I guess ultimately there should be someone that I have to answer to as far as licensing is concerned, I think that is important.

There may be other operators who may not -- not only private operators but non-profit operators as well. I mean, there is a Board of inspectors and if they are not meeting the guidelines then they should be forced to change as well. I mean -- did I answer...

Mr. Jackson: My final question has to do with your

reference to and innovative curriculum. Can you talk to us about some of your feelings about your curriculum and how it varies from your -- obviously, if you, in an open tender competition before the Metro School Board beat out 20 other applicants, there must have been something in your curriculum that appealed to that screening body and you beat out co-ops or non-profit agencies in that competition.

Can you talk to us a bit about the kinds of curriculum enhancements that you provide and why you are able provide them when, perhaps, not in all cases, but in your case the others were unable or unwilling to provide those curriculum enhancements?

Mr. Zelikovitz: Sure. It is difficult for me to answer really as to why someone did not do something who I really do not know.

As far as why the Board of Ed chose me in particular I think although they probably did look at my curriculum and compatibility with the school's curriculum as a factor, they also looked at marketability. The reason why the school had a day care come into their school is that their enrollment was low, they wanted to look at how they could bring more children from the area into the school. They thought that by providing day care within the school, their other enrollment would increase and, therefore, the community would save their school.

My other school is close to this public school and we are full, we are always full. So as part of my marketing approach to the Board, you know, I have a waiting list. I would gear the waiting list towards that school. So I mean, it was not only curriculum, there were other aspects as far as the school was concerned.

As far as curriculum is concerned, there are a real wide scale of curriculum and it is hard for me to say whether there are -- I mean, there are better ones and there are worse ones. My view has a middle approach. There is a Montessori method where there is a very structured curriculum and the children have a real formal day-to-day process. There are other centres where it is more of an informal drop-in or babysitting service.

In my school, in the old -- the programs really change from age group to age group. I have children one and a half years and I have children five years, so I have different curriculum within some of the different rooms. Within the oldest room, and this is basically from schooling, we try and work off the Dr. David Weichert's cognitive oriented pre-school curriculum where there is a framework; children have a choice within that framework as to what their activities are. There is planning with the children as to what activities they will be doing during the day. They

will do the activities and they are responsible for their actions. They come back and they report about the activities that they have done.

There is a planning chart on the wall. Every child has his name tag. They recognize their name. If they want to go over to the creative centre, they pick up a name, stick it on the creative centre. They can see the number 4. Only four children can go to the creative centre.

So they are responsible for their actions. When they come back to the circle, they are going to talk about what they did at the creative table, they are going to talk about their paintings. So there is continuity and it is a whole theme approach. And if we are going to the Art Gallery that day or if we are going to the zoo that day, we will incorporate, you know, animals into the theme, into the art, into the stories into the day, so there is sort of meaning and into the newsletters that go home to the parents so they can talk about the same type of things.

Mr. Jackson: Excellent. Thank you.

Mr. Chairman: Mr. Baetz, you are next.

Mr. Baetz: In your earlier comments you said that when parents phone up and inquire about a child going into your centre that they worry only about costs. I think that is about the comment you made.

Yesterday we heard from the Happy Child operator in Etobicoke, I believe, and if I recall it accurately, I think the point they were making was that when parents called about having their children go there, they were primarily concerned about the quality of care. Now, here are two private operators, one saying parents worry...

Mr. Zelikovitz: Okay, I will retract what I said.

Mr. Baetz: You will retract.

Mr. Zelikovitz: Not all the way though.

Mr. Baetz: Okay.

Mr. Zelikovitz: I guess when I hear a parent calling me up and saying how much, in my mind I go, what are you doing, I mean, that is not the right question. So I guess they stick in my mind.

By far a majority of the parents are concerned about the quality of care. I guess it is the ones that just call -- there are a lot of parents that call up just for price and I guess it really irks me because that is really not the most important part.

I would say by far the majority of people are interested in the quality, but there are certainly a lot of people who do not have the education to know what types of questions to ask and are not educated enough in child care to really be knowing what to ask and I guessing they have concerns about the dollar amount. But, no, quality is the real issue and that is where the issue is and really should only be.

Mr. Baetz: Yes. On another matter, describing your background and the reasons for leading you to your decision to become an owner and director of a day care centre and certainly where you were highly motivated was the matter of providing good quality care to children and you had referred to the fact that in recent months, recent times I think you said, the for-profit operators have been getting a pretty bad name.

Could you just follow that one along a little more and suggest to us why you think the operators are getting in some circles certainly "a bad name" and what can be done to correct that?

Mr. Zelikovitz: Okay. In a general sense, I guess the whole -- in my view it all goes to licensing. I think that there are groups of people, I guess advocacy groups who feel that -- their argument is that private operators will only adhere to the minimum standards and basically do what they can get away with and everything else is profit.

My argument is that Ontario's standards are probably one of the highest in North America and I think that as far as physical plant is concerned and ratios and square footage and all the rest of it, Ontario does extremely well, I mean, compared to the States, you know, you are talking 40 to 1 ratios and, I mean, some really just bizarre things and a really poor system.

So I think that there is a real bandwagon. I think that why commercial centres are getting a poor name is that there is only so much money in the pot and if there is going to be any money distributed to commercial centres, that means there is less money, out of that same bulk money, less is going to be going to the non-profit centres and I really think -- I look at it as in-fighting. I mean, I am on other committees within the day care community and a lot of it gets decided but a lot of it is just fighting between profit and non-profit.

The commercial sector feels that there should be a variety and the day care consumer should have a choice. The non-profit sector feels that, no, there should be no choice, it should just be non-profit and they spend a lot of their energies just basically fighting the commercial centres. A

lot of their energy is being paid consultants, you know, paid by the government, numbers like \$200-thousand a year strictly to, you know, push for a universal day care system.

So there is a lot of in-fighting from the commercial -- between those two sectors. I think that if all the energies were directed towards better day care and if it is the license requirements, if they feel that the standards should be raised or whatever the case is, then fine, let's sort of all sit down together, but not really exclude one sector from the other sector.

Mr. Chairman: Mr. Baetz, I do not want to interrupt you or limit your questioning, but we are now into a quarter to eleven and we have two more groups to hear from.

Mr. Baetz: I just have about one more question, maybe two short ones.

Do you carry on -- do private operators carry on any kind of on-going communication with the non-profit group? Do you get together around the subject of day care, child care?

Mr. Zelikovitz: Yes, I would say so. At Metro day care -- what is it called -- advisory committee, we represent the day care operators who provide the service that the City purchases from and we have all our issues that we talk and we debate. A lot of the times it is a real split down the middle between profit and non-profit but a lot of issues we really get together well on, that a lot of problems are solved, whether it be quality-- right now, there is a huge E.C.E. shortage and it is affecting everybody, whether it is commercial centres or non-profit centres; E.C.E. meaning teachers. So I think everyone is sort of realizing it is affecting everybody and we are all taking steps to look at the matter one way or the other.

So there is community. There are centres in my neighbourhood, I know the supervisor, I know their centre, they have come to my centre.

Within the schools in my neighbourhood, the public schools, children that go to J.K.S.K., the kindergarten teacher will come to my program to see if I can fulfill their -- the children's -- the rest of the day. So they come and look at me. They may have a non-profit centre within the school, but they are full, so we have sort of open lines of communication.

The problem is not there. I think the problem is with the money and like with everything else in this world, there is only so much and people have to be accountable but if one group gets the money and the other group does not, you know, it creates inequities, so...

Mr. Baetz: One final question, Mr. Chairman. That has to do with again going back to perceptions and stigmas and so on and that has to do with money, with the profit, and it is in your title and we heard yesterday from private operators and again from you today that the minute one asks about profit, how much does one make, how much profit did you make, there does seem to be a very, very clear resistance on the part of the private operators to not divulge that information.

I can understand perhaps why, but do you feel that perhaps one of your problems with public perception is that you want to hide the profit, how much profit you make because the minute you want to hide it -- you do not want to hide it -- the public reading is, you do not want to hide it because you are making too little, you are hiding it because you are making too much. Have you given thought to that?

Mr. Zelikovitz: Yeah, I have given that a lot of thought. And I am not hiding it because I made too much, I am hiding it because it is my business. And I do not feel -- I mean, I know I do not make much profit.

For example, if I have a purchase of service agreement with the City and all of my children are subsidized, which could happen, I am only allowed a ten per cent profit margin from the City. They are paying me ten per cent on top of my expenses for a purchase of service agreement, so in essence that is the profit. But I do not want to say that. I do not think it is anyone's business. It is my business, it is my private business.

I am running a centre, the children are happy, there are lots of toys, the parents are happy, I am not making a killing, I am making a decent living and I am working hard at it and it is very hard work and if the teachers can get a grant from the government to help them make some more in this field then, you know, power to them. But I can see it is a difficult situation.

Mr. Baetz: Thank you very much and thanks for your brief, it is very interesting, as far as I was concerned.

Mr. Chairman: Mr. Mitchell, I would hope briefly.

Mr. Mitchell: Very briefly.

I just want to go back to the figures that you used earlier. I think you said that you have 20 some odd children in the Moore Park facility but you are licensed for 32?

Mr. Zelikovitz: Right.

Mr. Mitchell: Can you just explain why that vacancy when we hear so much about lack of day care spaces?

Mr. Zelikovitz: Sure. I am full for September of '87. People are booking in advance. I do not want to take children in right now if I am going to have to kick out in seven months because other parents have booked. It is a new centre I start in September of '86. I think as a quality centre starts you probably should not open your doors day one with 32 children. It would be a real terrible situation for all.

Mr. Mitchell: Okay, fine. I just wanted to clarify that. Thank you, Mr. Chairman.

Mr. Chairman: Thank you very much, Mr. Zelikovitz.

Mr. Zelikovitz: Zel-i-ko-vitz.

Mr. Chairman: Zelikovitz, sorry. I was not here when it was gone through the first time. Thank you very much for coming. Your brief is very interesting and we thank you for it.

Mr. Zelikovitz: Thank you for listening.

Mr. Chairman: Okay, committee. The next person before us is Martha Friendly, is it?

Ms. Friendly: That is it.

Mr. Chairman: Well, it is nice to have someone friendly before us.

Ms. Friendly: I knew I would hear that.

Mr. Chairman: Centre for Urban and Community Studies.

Ms. Friendly: This is not a written brief, this is a bibliography that I wanted to give you.

Mr. Chairman: Okay. Perhaps you would just identify yourself for purposes of Hansard so we can preserve you for posterity.

Ms. Friendly: Okay. My name is Martha Friendly. I am a research associate in the Centre for Urban and Community Studies at U of T. and I have been involved in -- I am primarily a researcher and I have been doing research on child care since the mid-1970s. Even before that I did research on early child care programs and I would like to add that I have also been a consumer of child care for many years. I have been on a lot of parent boards and I really know about day care budgeting and hiring staff and how much you pay them and all that sort of thing. So I sort of know

it from both sides.

There are a lot of things that I could say about this. I guess I would like to apologize for having a fairly lengthy presentation and since it deals with the research on quality it may be boring. So if it goes on too long, please indicate that to me because I would like to keep it informal and I will try to be as brief as possible.

I would really like to talk about the research on the quality of child care programs as it relates to the mandate of your committee; that is, looking at the profit and the non-profit issue as something by which you can make comparisons.

What I am going to to is present you with an overview, a review of the existing research which deals with comparative quality and I would like to say that there is research, there is a limited body of research. A lot of research in the social sciences has limitations and I will try to point out the limitations. I am going to try to talk for ten or fifteen minutes, summarizing the issues and reviewing the main points of research and I am quite familiar with this research, and then, you know, I would like to be able to answer whatever questions you have, specific or general or whatever.

First, I would like to begin and I realize from being here yesterday that I think we need a definition of quality child care otherwise the discussion about what are we talking about is going to go on and on indefinitely. I think that generally in early childhood education and in child development, today there is reasonably good agreement on what constitutes high quality child care.

I would like to point out that in all of the debates which still go on about which begin: Is day care good for children, even the most steadfast supporter of day care, which I am, always qualifies the yes, we think day care is good for children with the proviso that good day care seems to be good for children. And in fact, and I am not sure if you are aware of this, in all the research that is presented to suggest that day care is good for children, most of that research has been conducted on good day care, a lot of it in university settings, at least adequate day care.

There has been very little research conducted on the effect of bad day care on children. So we really do not know that, but it is good to keep that in mind, that all that is talking about is good day care seems to be okay for children.

Now, if we are talking about a definition of what is high quality child care, day care, and I am using the terms interchangeably. I am trying to switch to child care

because the Provincial Government is adopting that as its term. I would like to propose a definition of high quality day care that was used by the Federal Task Force on child care as a working definition and that was the Katie Cook test which they reported last year, and what they used as their working definition of quality child care was this:

"Quality child care fosters children's well-being, development and competence and explicitly recognizes the needs of parents for care-giving that supports and strengthens their child-rearing efforts through effective and informative communication and mutual respect."

That is a very high blown definition. I would like to get more specific. From a substantial body of research, we know today that there are certain features of child care programs which are important in achieving that kind of high quality child care; that is, which contributes to good child development and I think this is a good summary of what these features are.

It is known that care-giver/child composition together is important and that is staff/child ratios and group size are important features.

Care-giver consistency; that is, that the same people are there, they do not quit, the same people are taking care of the same children basically day after day for a period of time.

Very important is training specifically related to early childhood education. That does not mean a B.A. in psychology, it means something like E.C.E. That is pretty well substantiated.

Parent involvement or the relationship between the parent and the provider and that is including family day care and I guess I am including family day care in all of these things. Some aspects of the physical environment and in family day care homes the regulatory status; that is, that they are regulated seems to have an effect on quality.

And there is a whole body of research that shows that these things are important for good quality day care. I will come back to these indicators of quality when I talk about the relationship to program auspices.

I would like to point out that today we have had the benefit of a lot more research on child care and child development than we had ten or fifteen years ago and that the child development field is in pretty good agreement about what good child care is and you would be very hard pressed to find people who disagree that these are indicators of quality child care.

Okay, I am going to leave that for a minute and I would like to move to making a couple of points which have to do with conceptualizing this whole question of quality and the comparison between profit and non-profit because I think there are some really important points to be made when you sort of conceptualize it.

The first point I would like to make is that right now this issue of quality in commercial and non-profit day care is very important because for the first time that I can remember, and I have been involved in this field for a long time, there is real discussion by government at different levels about making some substantial changes in the child care system, a big infusion of money, however you look at it and expansion of the system, the language has really changed from what it was five years ago and I think that that is very important. So the directions we take are extremely important.

The second point I would like to make and this was something that the commercial operators group said yesterday and I agree, there are several definitional problems in deciding which child care programs are non-profit and which are commercial. It is certainly true as Jeff Smith said, it is possible for an entrepreneur to assemble a board of three directors and take the profit out of their program as surplus. It is not exactly what you are supposed to do, but it is possible. The existing legislation does not really prevent that.

And it is also true that it is quite possible for an owner to operate a single child care program as a supervisor and not make a profit, as Joel was just saying to you. In fact, they make take a loss, and there are some other interesting definitional problems which were not mentioned and I will not go into because they are too silly actually, but in my opinion this is really a straw man or a straw person because it really does not relate in a large way to the bulk of licensed child care programs across the province.

It happens, it could be dealt with and I do not think that it should be the thing that is used to present as a barrier and say, we really cannot decide. Right now it is hard to decide from the figures which we have which are non-profit and which are commercial truly, but it is something that could be dealt with.

Another point I would like to make is that I think that the distinction which has been drawn between single-owner operated programs and corporate chains is really an over simplification of the issue and I think that the last study that I am going to talk about, which is the main Canadian study on this issue, really illustrates some

of what the problems in that are.

Fourth I would like to compare with what you said yesterday, Mr. Cordiano, that there it is not black and white, there are some poor and very poor non-profit programs and there are some good commercial programs. I am sure you are aware of that, but the point I really want to make is that on balance the research shows that the commercial sector as a sector offers poorer care than the non-profit sector and I think this is a social policy matter, it is not a matter of this operator runs a good commercial program and this non-profit program is terrible and ought to be closed down. We are talking about a broad social policy and I would really like to, you know, talk just very briefly about the earliest study that I think has ever -- that I ever found -- and this is not a Canadian study it is an American study -- which looked at comparative quality in commercial and non-profit care, it was carried out in 1972 in the U.S. by the National Council of Jewish Women.

Mr. Chairman: Is that referred to in your brief?

Ms. Friendly: Yes. And basically what it shows is that there is a continuum of quality and I think that when you look at the research, all of the research and look at the research we had today that that is what we are talking about is continuum of quality from very poor to excellent and then a lot in the middle.

And I think that that 1972 study showed what much of the other research shows and our most recent Canadian study shows that the commercial programs tend to be at bottom end and very rarely at the excellent end and skew the whole field down. And I think that that is may be the way you have to think about it. It is not whether one is here and one is there and that sort of think but that is basically what the research shows.

And the last point I want to make-- this is the last point I want to make and then I will get into it. From common sense and from looking at all of the available research, it is obvious that whether a child care program is commercial or non-profit is not the only thing which makes it likely to be good or bad. There are two other factors which seem to be important: One is funding and the other is the system of regulation. I mean, of course, that is obvious if you look at -- across the board, if you look at child care programs in Ontario, they are better because the standards and the whole system of regulation is better than they are in some other provinces and in American states and you cannot ignore those things, but it is quite true that auspices is another, is another important factor.

Now, after this very lengthy preamble I would like go to on to talk about the available research and I should add

that last summer in preparation for my presentation to the Federal Special Committee on Child Care when they came to Toronto to have their public hearings, I spent a lot of time trying to identify anybody in North America who was doing research on this issue and if anybody can come up with anything that I have not found, I would be really surprised and eat my words, but I think I am pretty aware of who has done anything that bears on this issue.

The only thing that would be in addition to that bibliography that I passed out to you is the recent Canadian survey done for the Special Committee on Child Care which I will talk about last and that is not on that bibliography.

And I think that you should keep in mind that although this is not a substantial body of research, it really does confirm all of the anecdotal information that you have if you are in this field, may be some of things that you have heard, and also that it is all in the same direction, is that: There is no evidence that as a sector it is equivalent or better or that there seems to be any particular advantages. The limited body of research is all in the same direction.

Okay. I am going to go through, as quickly as I can, some of those studies and I have grouped them into variables and I will go through them as quickly as possible. Okay. Should I? Yes? Okay.

Mr. Chairman: Sure.

Ms. Friendly: Okay.

Mr. Chairman: We are friendly as well.

Ms. Friendly: The first thing I want to talk about are salaries, benefits and working conditions which I think you have already heard a lot about. Salaries, benefits and working conditions seem to be related to some aspects of child care programs like staff turnover and staff training and actually there is a person in California, Marcy Whitebook, who has a big research project called the Child Care Employee Project which has linked poor salaries and working conditions to higher staff turnover and I think that that is sort of a matter of common sense. I mean, that is only thing that clearly links it.

Now, I am sure you probably know or you probably read in the papers in the last few years that there was a major Canadian study done as part of the Federal Task Force on Child Care that found substantial differences in salaries and benefits between commercial, non-profit and municipal child care staff across the country and the figures that that study revealed were that staff in commercial centres make 30 per cent less than staff in non-profit centres and

50 per cent less in staff in municipal centres and I should point out that all almost all the municipal centres in Canada are in Ontario and a good chunk of them are unionized.

They also receive fewer benefits in every category than staff in non-profit, staff in commercial centres and that was vacation, professional development, you know, clear benefits like contributions to health care and all those kinds of things, there is a whole list of benefits.

There was a piece of Ontario research conducted last year by the AECEO, the Association for Early Childhood Education in Hamilton that found the same thing in Ontario and that is the only clear Ontario piece. They said that for-profit staff people were paid poorer salaries, provided with fewer benefits and less professional opportunities than their counterparts in non-profit programs and I think you have the reference to that.

And then I guess the other American piece of research is the one that Marcy Whitebrook found, one of here studies of staff in commercial centres reported more on-the-job tension and received fewer benefits and that is the summary to that.

Let me just talk a little bit about staff turn over. I do not think I need to talk about why that is considered to be an indicator of program quality. I mean, it is sort of obvious, so I will just leave that.

There is a big paper that was done by Chris Baggley at the University of Alberta. He is the Chair on social welfare research and it is not a really an empirical paper, but it has pulled together a lot of anecdotal information from Alberta, and this is not among bibliography because it is not research of the same type, but he talked about poorer wages and working conditions creating a kind of revolving door in commercial day care centres in Alberta and I think that paper is worth looking at. It is not research in the same sense.

The AECEO study in Hamilton found higher staff turn over rates in commercial centres, as did Marcy Whitebrook in her work in California, and one of the things that she said that was kind of interesting, I pulled a little piece out, she said that in her work, and this is a quote:

"Turnover rates were highest for staff in proprietary centres which were the ones with the poorest ratios, worst reported working conditions, fewest benefits and most stated tension. The high degree of tension in proprietary centres may well be a response to the high rate of turnover as well as the cause of

it."

So it may be hard to separate what is a cause and what is an effect.

I want to talk about staff/child ratios. I think, as everybody has said, the staff/child ratios in Ontario are quite good, they are close to what is recommended as the ideal ratios for quality child care, not so much in the toddler area, they are not quite right, but they are pretty good. They are set by regulation.

Staff/child ratios may vary even within the framework of regulation in a couple of ways. First of all, regulations are minimum standards and they usually set only a minimally acceptable base line rather than guaranteeing high quality. In Ontario if you meet the ratios you are doing pretty well. In the other provinces that is not so much true.

Second of all, even with reasonable enforcement of regulation, it is difficult to guarantee that all programs are in compliance and with poor or infrequent monitoring many programs may not comply. In other words, the day nurseries inspector or consultant cannot knock on a day care centre's door every day or every week. In Ontario their requirement is that they monitor once a year, okay. And sometimes, you know, you can do things like counting a cook as a staff person, you can juggle people around a bit so that your ratio of people actually working with the children may not be exactly what it might be. I mean ratios are pretty fixed, but there is a possibility for variation.

Now, there really is no -- until the recent federal study, there has never been any Canadian research that looked at the differences in ratios between commercial and non-profit day care centres. In the States a really quite good study actually that was done in Pennsylvania found that for-profit programs in their status were much more likely to have poor staff/child ratios and Marcy Whitebrook found the same in her work and she found some extremely poor ratios and she found as many as 78 per cent of the staff in the for-profit programs in her sample were working in programs which had ratios of 1 to 11 or more and that was for kids from two and up. And I do not know if you are familiar with day care programs, but that is a pretty high staff/child ratio.

There is a very good PhD dissertation that has been done by a guy at UCLA and I have talked to him at length. It is interesting because he has a PhD in developmental psychology but he worked in day care for years, so he really knows how a day care centre works and I found it quite instructive to talk to him and he shared his data with me actually.

He found in ratios that in California the regulations for licensing require a ratio of 1 to 12 for pre-schoolers, kids aged about three to five and he found in -- well, he found statistically significant differences between the commercials, the non-profits, and the publicly-funded centres which is somewhat different in California because they have a different set of criteria.

And I just want to describe to you what he -- told me what he found. I mean, if he had to describe his typical commercial centre based on the child development scale that he used he described it to me as a 'sit down and shut up' program and I just want to read this to you because it kind of illustrates what we are talking about.

He said that these programs have:

"Some developmentally appropriate equipment around on tables and some puzzles but they are not necessarily age-appropriate. Some adult child interaction but not much. Interaction is mostly of the do/don't variety. There may be group activity, but if an adult reads a book to a group of kids the adult may not hold the book so the kids can see all the pictures. Children may not be involved with the activity, but the adult goes right ahead with the story. Outside there is probably a jungle gym, maybe swings, maybe a ball or two. Almost never sand or anything messy. Maybe dolls and maybe a dolly centre, but certainly not other dramatic play like a store or restaurant. Not much of a program; it is basically custodial."

And he was talking about kids as young as two being required to sit at desks and do seat work in these programs where the ratios were not high enough to do much more.

Okay. And I just want to talk about staff training. In Metro Toronto another PhD dissertation is being done on some of these differences, this time by a geographer who is doing her -- is just about finished at U of T and she surveyed all of the licensed day care centres in Metro Toronto by telephone and, by their own report, the mean ratio of trained staff to untrained across all programs that she surveyed was 75 per cent of all the staff in -- for all the programs -- for-profit programs reported a mean of .64 and non-profits reported a mean of .81 and the Metro-operated centres reported that all staff were trained in early childhood education. This is all the licensed day care centres and there were quite clear differences between the commercials and the non-profits and, again, the municipal centres.

One last bit of data is that one piece of research conducted on the incidence of infectious illnesses in day care by a pediatrician down in the States reported a number of characteristics associated with a high incidence of outbreaks of various infectious diseases, things with names like Shigella and Rotavirus and Giardia Lamblia and things like that which are mostly diarrhea, and what he found was a large -- these were related to having a large number of children in diapers, poor regulations, poor training in infection control, poor health care practices, poor ratios and for-profit status. And that was a 1984 study, it was reported in 1984.

And there are two main American studies which actually went in and observed day care programs where you take a scale of quality. Both of these use something called the Harms and Clifford scale which is very widely used. It is a seven point scale on a number of items and you have trained observers going in and rating all of these items on this scale. It is a very good scale, it is used a lot for self-evaluation in day care programs. And both of them reported statistically significant differences in samples, one in Pennsylvania one in California, between commercial and non-profit day care centres.

Okay. Just leaving all that primarily American research. Until this year we have never had really any substantial Canadian research that looked at these kinds of differences. I am sure you have all heard about this study that was released early, I guess, by the federal-- that was commissioned by the Federal Special Committee on Child Care that was done by SPR Associates and I really would like to say that there are a number of real problems with this study and I will say some bits about what they are, but it is really important to consider it because it is the first research that really deals with this issue across Canada. We have never had any research on this issue in Canada before.

The first problem with it is that I think that the measures that we use are really a gross way of measuring quality and I mean not very precise. I mean what they did was, it is a survey basically of the licensing, the inspectors. It was quite a good sample of inspectors and it is a sample of a thousand of the four thousand day care centres in Canada, but the people who are doing the ratings were the licensing inspectors. They are familiar with the programs, you have to say that they probably have some interest in their programs being-- at least meeting the regulations and they are not observations, they are retrospective, okay, so I really would like to emphasize that.

I think that another serious problem with this study is the analysis which follows the findings on the surveys and

it is really riddled with problems which I will not go into, unless anybody wants to talk about.

I would like to discuss the findings though. The study used ratings of very poor, which means: In violation of important provincial standards and extremely deficient. Poor: Falling short of some provincial standards, not meeting the criteria. Adequate meaning that they are right on the provincial standard mark. Good: Providing better than the standards required, and excellent.

And what the survey found was that for a thousand centres statistically significant differences, all of them were statistically different, that the government-operated centres were the best rated this way. 80 per cent were either good or excellent. 50 per cent of the non-profit centres were good or excellent. A third of the small commercial centres were in this category and 29 per cent of the chain day care centres, and none of the chains were rated as excellent, they were all-- all of the 29 per cent were in the good category.

In the categories of poor or very poor, which means in violation of provincial standards - and I want to emphasize that some of these provincial standards are not very stringent because this is across Canada - only two per cent of the government-operated centres were in the poor or very poor category, a tenth of the non-profits and a quarter of the small profits centres were in the poor or very poor category.

And the thing that was interesting that this study found was that the chain commercial centres really did seem to fall within the middle category, that they were not excellent and they were not at the very poorest end. They seemed to be more likely to fall close to the required minimum standards than the small commercial operators, which is kind of interesting, because it is a much more complicated issue and chains was more than one in every case. I mean this was-- I think they considered a single owner-operated centre to be a small commercial operation and the rest were chains and I think that was quite interesting.

And they use another method, there was another part of this survey where they asked the same raters, the licensing people, to rate centres on a whole list, 27 dimensions of quality and it is quite a good list. It includes things like group size, ratios, adult/child interactions, staff turnovers, staff training parental rental involvement, support to parents, support of parental values, responsiveness to variations in community need, nutrition, health/safety protection, administration of the day care program, financial management, things like that.

I am just about finished up here. And almost every

one of these dimensions, except availability; that is whether there were vacant spaces, the order of the ratings was just about identical. The government-operated centres were best, non-profits were next, small commercials were next and chains were last and sometimes the small-- the two commercial categories were reversed.

And I would like to leave that and take your questions, if I have said enough about summarizing the research. I have tried to do a thorough job to sort of get the discussion further ahead and I would to entertain any questions that you have might have.

Mr. Chairman: This is just in advance of questions being asked. I have been advised by our researched, Kathy Fooks, that Ms. Friendly made all of the reports available to her in advance so we do have them, we have information on them and if any of them are required for the committee we can have them and I want to thank you for that.

Ms. Friendly: You are welcome.

Mr. Chairman: Yes, Ms. Hart and then Dr. Henderson.

Ms. Hart: Okay. I just have a quick question about the government study that you were just talking about, the federal government study.

You said the categories of rating were poor, good, adequate, but you did not specifically say that each province was regulated separately. Do I take it from what you say that..

Ms. Friendly: Yes.

Ms. Hart: ... since the standards in Ontario are higher, in Ontario adequate might be the same as a good in another province or perhaps even an excellent?

Ms. Friendly: Yes. I mean there is a couple of things. One thing is the data was not analyzed so that you could tell any variations amongst provinces, which I think is a real flaw. They were rated against the standards of the province and that is why I said that measure is extremely gross.

You know, essentially they were asking people within their own province against their own provincial standards to say how these centres matched up. So you are right.

Ms. Hart: So you cannot really make generalizations across the country based on that data?

Ms. Friendly: Yes, you can make some generalizations because the findings were held -- were statistically

significant so that across the country, even though we do not know province by province, in general the commercials stacked up worse, but you do not know what it meant in terms-- on that measure, you do not know what it actually meant in terms of what the centres look like province by province. Is that...

Ms. Hart: Hm-hmm. Okay, thank you. That is it.

Mr. Chairman: Dr. Henderson?

Dr. Henderson: Thank you very much for a really quality presentation. It is nice to hear such a systematic approach to a complex issue.

I just have one or two comment questions. I was a little troubled, not by the study, but by what interpretations might be made of it, of the earliest study you mentioned using U.S. - I guess a U.S. study and presumably U.S. facilities - that found that non-profit were generally of better quality than private sector operations, because when you start comparing private versus public sectors across countries it seems to me that there is an awful lot that can be quite invalid about the kind of comparisons you make and the conclusions you draw from them.

What do you think about that? Do you think that that study is applicable to the Canadian situation or can we say that it belongs south of the border and it is of interest, but not necessarily relevant to us?

Ms. Friendly: Well, I mean, I agree with you to some extent. I mean, I think -- I mean, I am quite familiar with the child care situation in the States because I used to live there and I did research in the States and I think that there are a number of ways that our child care situation is quite different.

I would be much happier not to use American studies, I think that they bear somewhat, but you have to take them with a grain of salt.

Dr. Henderson: Could they be misleading?

Ms. Friendly: I do not think that they are misleading if you know enough about the studies to really look at them and I mean, for example, if you look at the staff/child ratios and group sizes and the whole standards in day care by state and you look to see where they were done and you understand about the funding arrangements, you can extrapolate from them.

For example, you would not want to use studies that were done in places like some of the southern rim states, or Florida where the day care is, you know, I mean really

bismal. I think that if you look at child care in places like California and Massachusetts and New York and some of the New England states, these studies tended to be done -- Pennsylvania also, I think you can have a fair sense of what is going on.

I think that the principles are the same of operating child care for-profit in the United States to Canada. There really is no difference in the funding with the exception of the fact that I think that day care in the United States tends to be more ghettoized; that is, children who are subsidized, are much more likely to be in publicly-operated day care in the United States than they are in Ontario or across Canada.

So I appreciate what you are saying and I agree with it to some extent, but I think you have to take these things into account and I just want to say also that there is no other comparison because we do not have -- there is not any other country which has a large component of commercial child care than the United States and unfortunately most of the research we have to look at is American and I do not like doing it either. I wish we had more research.

Mr. Leluk: Can I ask one supplementary?

Just going along on Dr. Henderson's comments, how did you come to select these particular studies? I am sure there must be many other studies or were these -- is this the total component of everything?

Ms. Friendly: That is it. I really did spend about two weeks calling up, you know, all the major researchers certainly in Canada and North America and trying to find anybody -- that is how I found these PhD dissertations -- who is doing research in this area? That is it. I wish there were more.

Mr. Leluk: Well, it does not speak very highly for...

Mr. Chairman: There will be one more.

Mr. Leluk: Pardon?

Mr. Chairman: This committee will be the next one.

Mr. Leluk: Yes.

Ms. Friendly: I hope so.

Mr. Leluk: Yes. Well, I am rather surprised that this is the total extent of all studies done in this field.

Ms. Friendly: There is not that much research done in the field period, in the whole field. You know, you can put

it in a room, I have it in a room.

Mr. Leluk: I have to agree with Dr. Henderson that I think some of these results could be somewhat misleading. When we look at the Canadian scene, there may be some relevancies, but...

Ms. Friendly: That is why having the federal study with its problems is important because it does not look that different. You have to -- you know, just like any other social science research, you have to take it in context and say, you know, well, if you have five studies and they all say the same thing, they have these limitations, but you have to at least think about them. I guess that is the way I am trying to present them.

Mr. Leluk: Thank you, Mr. Chairman.

Mr. Chairman: Mr. Mitchell, before you have the supplementary I just want to inquire -- Mary Ann Wasilka.

Ms. Wasilka: Here.

Mr. Chairman: We are getting close to the bewitching hour and I am wondering whether or not you are able to come back this afternoon at two o'clock?

Ms. Wasilka: Not really.

Mr. Chairman: Well, I wanted to know that so that the committee would be aware of that.

Ms. Wasilka: Our presentation will not take more than 15 minutes.

Mr. Chairman: It is not the presentation I am worried about, it is the questions, but committee, you have heard that, so let's try and accommodate them and we have to go beyond the normal 12 o'clock.

Okay, Mr. Mitchell?

Mr. Mitchell: Just following that line of questioning, you say that these are all the studies. You are obviously referring only to North America.

Ms. Friendly: Well, it does not come up in European countries because they do not have -- well, there really is not such a thing as commercial child care in European countries.

Mr. Mitchell: Not even in Great Britain?

Ms. Friendly: Great Britain is a country that has very little child care, strictly speaking. They have infant

schools, but they are not child care, okay. Now, in Australia there is commercial child care but it is not publicly funded. They may consider it.

Mr. Mitchell: There is no public funding of child care in Australia?

Ms. Friendly: No public funding of commercial child care and I have never found any studies that they have done on the differences, although I have looked.

Mr. Mitchell: That is an interesting...

Ms. Friendly: Something may have escaped me.

Mr. Mitchell: Perhaps our researcher may try and find out what does exist with regard to -- you know, I am not disputing your ability to research, it is just that we have something we can deal with between governments, I would hope, to try and find out.

Ms. Friendly: Yes, that would be good.

Mr. Mitchell: Thank you.

Mr. Chairman: Dr. Henderson, do you have any further questions?

Dr. Henderson: Yes. Thank you, Mr. Chairman.

My second question is a little on the same lines. It occurs to me that what one is trying to research in this business is something like the quality of nurturance -- the quality of care and the quality of nurturance which is an extraordinarily difficult thing to research and it was partly for that reason that that stark ranking of order of excellence - I realize it is not exactly that - but it sounded like order of excellence: Government best, non-profit second, small commercial third, and chains fourth.

I do not quarrel with it either, if that is what the research shows, but I was trying to think of an analogy that might illustrate my concern, and having an academic medical background, I was thinking of medical research where everybody agrees that good research is research that is systematic, well controlled, well funded and well monitored and so on, except that when you stop to think of the important advances in medical care, most of them have not come out of that kind of research. They have come out of random, kind of individually-inspired, individually-passioned, sometimes even quite accidental, haphazard, uncontrolled. A lot of very important advances have come about in that way.

So I am uneasy when I here such a complicated question such as the quality of nurturance reduced to ranking in that sort of way and I think I sense from your tone of your remarks that you were uneasy about it too. And I am wondering if you could shed any light on what interpretation we ought to draw from that.

What does that mean? What does it mean, for example, that the commercial generally and the commercial chains particularly seem to fall toward the lower end of quality of nurturance and and ought we to think of improving that, leaving the context within which that care is given in tact, or ought we to conclude that that means that the commercial sector does not have as much of a place as publicly-funded programs?

Ms. Friendly: Well, I just want to -- let me answer that, but I just want to say it is not commercial or publicly-funded, I think what we are talking about is public funding for child care programs and whether that should include commercial or not.

Dr. Henderson: Yes.

Ms. Friendly: Okay. What I would like to say is that -- you see, it is interesting. When I said I thought that that rating is gross, it is because it is not very precise to say excellent, I mean I think you raised this point, but I do not think we are talking about the quality of nurturance.

What that means -- I mean I am not sure if this is what you are saying -- that child care or early childhood education is like mothering or fathering and I do not think that is really what we are talking about. What I was trying to say at first is that from the whole field of child development and developmental psychology, we have learned something about optimal development for children. We know something about those kinds of environments...

Dr. Henderson: And that is different from nurturance?

Ms. Friendly: Well, no but that is one element. I mean, it is certainly one element in it but I think it may be a bit over simplifying it.

Let me just expand on this. And that based on that, all of that knowledge, we have learned something about what makes good quality child care because good quality fosters that kind of optimal development in a child care setting and that those features are things which you can quantify and observe and look at and I am not saying that this study did that in a precise way, this Canadian study.

I am saying it did not do it in the best possible way and it is not great research from that point of view, but I do not think we are saying that you cannot quantify the quality of early childhood programs.

Dr. Henderson: What did the study actually measure? And what did they go in and look at?

Ms. Friendly: They did not go in and look at anything. I think that is the real problem. What they did was they got a sample of the licensing inspectors, the day nurseries consultants from all the provinces across the country and they said to them, the ones that were selected, of the day care centres that you license that are under your jurisdiction, can you rate them on those five factors.

Dr. Henderson: They could have been just measuring the bias of the rating?

Ms. Friendly: There is definitely that and I said that at first and actually when I first heard that they were going to do the study this way, I was quite concerned about it because I thought that will be an incredibly biased study because, of course, if you are the person who licenses you have a reason not to want to say that your centres are not conforming to the regulations. There is that.

Mr. Jackson: Or if you are of a union and you are asked to evaluate, your criteria could be based on those that are unionized and those that are not?

Ms. Friendly: But also it was interesting that even with that they did turn out with such a large number of programs that were not meeting the programs. I mean I think that is pretty interesting, if you assume this is likely to be a somewhat biased rating. They were anonymous and all that sort of thing, but I have to assume that.

How this research was done - I mean, I hope that this is not the last piece of research that is done on this issue in Canada - but it is the first piece and that is why it is important and because I do not think that if you do things in a complete haphazard way -- I mean, if you get statistically significant findings it says something to you. It does not say that it is the last word, but it says something to you.

Dr. Henderson: It can be statistically significant and it can be irrelevant to what you really want to measure.

Ms. Friendly: Yes, but this is not irrelevant because you are asking the people to rate the centres who actually go in and inspect them. So you cannot -- I mean, I think you have to take it in some context. It seems that it is relevant. I think that people were relatively satisfied

with the way it was done, given the limitations of the way it was done. It is a thousand ought of four thousand centres across Canada, I mean and, you know, there were two different ways that they rated these centres. They rated them in that gross way and then they rated some selection of those with this list of 27 dimensions which were quite good when you are looking at the quality of nurturance, and they came out with the same findings.

That is why I am presenting it. I think you have to take account of it.

Mr. Chairman: I do not want to interfere, but I have two more questioners. Do you have...

Dr. Henderson: I will pass.

Mr. Chairman: Well, no.

Dr. Henderson: Well, my final comment or comment question was going to be: Would it not make a lot of sense, if we are going to draw conclusions from research to have some research that actually looks at the kind of interaction that goes on between the care givers and care receivers or there is not much of that I gather from what you say.

Ms. Friendly: There is none in Canada.

Dr. Henderson: Which is really a serious deficit if we are trying to evaluate.

Ms. Friendly: I think so. I mean, it obviously is and that is why what I have tried to do is present what there is and say you have to look at it, you have to recognize what its limitations are, but it says something.

Dr. Henderson: Thank you, Mr. Chairman.

Mr. Chairman: Thank you. Mr. Baetz?

Mr. Baetz: Earlier in your presentation you pointed out that two very important factors in all of this are funding, and I gather that means level of funding and a system of regulations.

Are you suggesting that these two factors by applying the equal funding and equal regulations to the whole system whether it is for-profit or non-profit or whatever, chain, the whole thing, that these rather dramatic differences that you have described to us could be largely flattened out or erased?

Ms. Friendly: I do not think they could be because I think that those two factors are important, but I think that another factor that is important is who is running the

centre.

I mean, let me describe this. If you have a non-profit day care program, like my child's day care program, with a board, parent board and you do not have any other funding except parent's fees and subsidies, basically that is what the funding is right now in Ontario, so we can provide a day care program. You take all that money from the parent's fees and subsidies and you balance off how much you can get your parents to pay and you pay your staff as much as you can. The staff make quite good wages for day care in my kid's day care centre.

If you are a parent board or a community board, your interest is in doing that and putting all the money into the day care program. If you are a commercial operator, whether it is ten per cent, I mean, the wages across the country and in Ontario are 30 per cent less, there is an incentive to take money out --

Mr. Baetz: Across the board?

Ms. Friendly: The non-profit programs. There is an incentive to reduce aspects of the program because you have to make money out of it, basically. I mean, I am not talking about the few that do not or how many do, or how many do not, I mean, basically that is what the private enterprise system is all about, it is to make money, basically, whether your group is selling shoes or day care. And I am suggesting that there is a contradiction in those two things.

I submit that if you provide a direct grant across the board, suppose you raise all the workers' salaries in Ontario by factors, say a thousand dollars a year, two thousand dollars a year, you are still going to have what exists now is a 30 per cent discrepancy between the commercial and the non-profit. So, therefore, the jobs will be less attractive.

Mr. Baetz: No, but let's assume that that is correct though, that they all get the same.

Ms. Friendly: Well, how are you going to do that because the profit factor is the thing that is taking the money out of the wages and the other aspects of the program. How would you do it; give a larger direct grant to commercial day care? That is the only way you could do it, unless you said people could not make a profit.

It is the profit that you are taking out that reduces the wages which is related to the turn over, the unsettled working conditions and whatever other sludge there is in there. It is mostly wages.

If you have a shortage of early childhood educators which we do now in Ontario because people do not stay in the field because the wages are so low. And I know this because I have tried to hire staff people. They do not want to make \$12,000 a year or \$13,000 a year if they can make seventeen or \$18,000 a year and that is part of the problem, and they do not stay.

I had a woman come to see me recently who is doing some research who is a staff in a commercial day care program, pretty nice person, she was doing her E.C.E. and finishing and she was the only trained staff in her group, meeting the minimum requirement in her commercial day care centre and she said, when I finish my E.C.E. I am going to leave and get a better job.

You see, that is what you are dealing with. You have to give a bigger chunk of government money or you could charge the parents more in commercial day care. You could do that, you could charge the parents more than you do in non-profit day care to make up the discrepancy in wages and other elements of the program that have to do with taking the profit out of it.

Mr. Baetz: Well, in what way then did you mean that funding and system of regulation makes the difference or could make a difference?

Ms. Friendly: Okay, system of regulation is the standards which are set, laid out and then how you enforce them, how you monitor them and how you actually enforce them, that is the system. If you have a good one, better minimum standards, better monitoring and enforcement which we do have in Ontario, it raises the whole base line, the floor. You still have a floor but it is higher in Ontario than it is in Alberta. That is all there is to it and in other places, the floor.

But that does not mean that that floor is quality day care. There is a real difference in a day care program where you have one trained staff in a room with toddlers and mostly all. There is really a difference if you go into a day care centre that is running that way.

I mean, believe me, as far as funding it is a very complicated formula right now because if you are a community based non-profit day care centre in Etobicoke or Scarborough or some place and you are not in a very affluent area, but they are not people who are getting subsidies -- you know, people are caught in that squeeze -- you cannot charge your parents very much money and that is your funding, is from your parents, you know, or it is from subsidies of people who have a low income and up.

That is why centres who have all subsidized children

or virtually all subsidized children have better funding because you do not have to keep the fees down in the same way.

The other element of funding is, if you are a day care centre, for example, like one of the community college day care centres that have infants, that everybody knows are really high quality because they are a lab school, because they have got students and all that kind of thing. What they have are parents lining up to get into those day care centres and out of that bunch of parents that are lining up on that waiting list there are going to be a whole bunch who can pay \$150 a week so they do not have to worry about their funding so much either.

That is part of funding. It is very complicated because there is no real funding. I am saying that profit or non-profit, if a day care centre is really really squeezed, it is going to have a problem and that is, of course, where you have this overlap, but it is one factor and so is regulation and so is for-profit status.

Mr. Cordiano: A supplementary, Mr. Chairman?

Mr. Chairman: You are on the list next.

Mr. Cordiano: Oh, okay.

Mr. Chairman: And I think Mr. Baetz is finished, I suspect he is anyway.

Mr. Baetz: I think the Chairman.

Mr. Chairman: Thank you very much.

Mr. Baetz: No, that is all right.

Mr. Chairman: Mr. Cordiano?

Mr. Cordiano: I just wanted to pursue in the same vein. So what you are saying, essentially, is that whether it be a not-for-profit centre or a profit centre, a commercial centre, funding is a key in the sense that if you are going to have the affordability -- let's talk about affordability and accessibility because those are interrelated with what you are talking about as coalition of funding.

If you can afford to pay a certain amount and this centre is properly funded or it has enough revenue, it is going to be able to do the kinds of things you are talking about; have high quality of child care.

Ms. Friendly: Yes. May be I could respond to that by saying that there is not -- like, suppose you are a

commercial centre and there are a couple of chains like this in the States, we have not really seen them here yet, they are kind of called yuppie day care, okay. There is a real demand for day care by upper middle income people who can pay a lot of money and so what they can do is they can pay decent wages and make a profit. I mean, I can direct you to one chain that is doing this.

Mr. Cordiano: Sure.

Ms. Friendly: But they do not get public funding and there are kind of -- you know, that is basically their message, we will make your child a better child, we will teach French and computers and that sort of thing. I have seen a couple and, you know they are pretty nice looking and all that sort of thing, but you were saying, Mr. Henderson, that there is a difference between -- I think that is an American approach to things and I think that we have not really taken that approach here. We are talking about a basic public funding base. Except for that, I do not think you can do it.

Mr. Cordiano: Well, essentially what we are talking about is making it more accessible, more affordable to a wider range of people. I mean that is the key. If we can do that sort of thing in a broader sense, well, geez, everybody would love it, but is that what we are really talking about?

Ms. Friendly: No.

Mr. Cordiano: I mean we have got to move to this point where we have reasonably high quality child care in Ontario that is more accessible, that is more affordable, and when we talk about the profit centres or not-for-profit centres we have to remember that we are talking about having more accessibility and reasonable quality and making it more affordable to a broader range of people.

So I mean, if we are talking about increasing revenue, we heard from commercial operators and they suggested: Well, if we can increase our revenue, then certainly we are going to have a better base to work from and our cost factors are going to remain the same or we are going to be able to pay our staff better salaries and better benefits.

Ms. Friendly: They could pay their staff better salaries now if they were not making a profit out of the day care, they could pay as well as non-profit day care centres. That is what I am trying to say, if you want to put public money into that, I mean if one wants to put public money into, that is a policy decision, but I am saying if you put public money into day care across the board, you are still going to have a situation where there is a difference because the non-profit centre does not have to take a profit

out of this. All this business about surplus aside and all that sort of thing that we heard yesterday. I am saying that you will still find a difference in the wages. How will you equalize the wages?

Mr. Cordiano: Well, let's look at a system of direct grants, that is what we are talking about essentially. If we are directing or targetting that to the staff that is lower paid and bringing their salaries up to the level of, say, the not-for-profit centres...

Ms. Friendly: You mean you are going to give direct grants only to commercial centres.

Mr. Cordiano: I am not saying what we are going to do.

Ms. Friendly: I do not think so.

Mr. Cordiano: I am saying if you try to bring up salaries right across the board, if you are going to bring it up to some level, some average wage that is acceptable that most people would say, well, it is still low. I mean, we know that, but...

Ms. Friendly: I would be happy...

Mr. Cordiano: But measuring it within the industry or within that sector.

Ms. Friendly: Do you know what, you have to understand a day care budget to understand this and I would happy or someone else to go through one with you. The fact is that given the present situation, let's say we agree that there is across the country and in Ontario, say there is a 30 per cent discrepancy in wages on an average.

Mr. Cordiano: That is across the country.

Ms. Friendly: It is in Ontario too.

Mr. Cordiano: It is in Ontario. Okay.

Ms. Friendly: I do not think anybody would disagree with that, okay. If you give a direct grant, assuming that it is the same direct grant to the commercial and the non-profit and it is entirely directed to wages, there is still going to be a discrepancy.

Mr. Cordiano: Well...

Mr. Chairman: Mr. Cordiano, Mr. Cordiano, we are really getting to the stage where it is...

Ms. Friendly: We will do what we can do.

Mr. Chairman: ...where it is a sounding board and I do not want to cut you off but we do have one further presenter and I think perhaps we should hear from her.

Mr. Cordiano: Fine.

Ms. Friendly: Yes, I think I have taken enough time.

Mr. Jackson: Perhaps, Mr. Chairman, as a request we could invite the deputant back because there are gaps in our program, in our docket.

Mr. Chairman: Ms. Friendly, would you like to come back?

Ms. Friendly: Sure.

Mr. Jackson: Because I have a series of questions but I have been practicing unusual and uncustomary restraints.

Mr. Chairman: I understand, your restraint is outstanding.

Ms. Friendly we would like to thank you. It was a very thought-provoking presentation and we would certainly like to have you back if you are available and perhaps we can have the clerk speak to you as to when you might come back.

Ms. Friendly: Sure, that would be fine. Thank you very much.

Mr. Chairman: Thank you very much.

The next group -- there is a printed brief that has been handed out to you. It is Providers and Children Together Association, Mary Ann Wasilka.

Ms. Wasilka: That is fine. That is close enough.

Mr. Chairman: It is close enough. Okay.

Ms. Wasilka: Thanks for seeing us today.

Mr. Chairman: Before you do any talking you have to sit down and the reason for that is so that the Hansard can pick it up and report it accurately. You have to speak into the microphone. Perhaps before you do that you can identify yourself and the lady to your right.

Ms. Wasilka: My name is Mary Ann Wasilka. I am acting president of Providers and Children Together. We are a group of home day care providers who contract services for the Region of Waterloo and this is Carolyn Bleackley, she

is our fund raiser and as soon as we have enough funds, she will become our resource person.

Ms. Wasilka: Our Association is made up primarily, I would say about 99 per cent, of private home day care providers who contract services for the Region of Waterloo.

It is our understanding that about 80 per cent of all child care is the informal type of child care; that is, in the home type of child care. There are several reasons why parents prefer home-based child care: It is closer to their home, the hours are more flexible, it is more like they provide service for school age children, especially in our region and they may be supervised by a parent or aunt or sister somebody the parent is familiar with. There are many other reasons why people use informal child care and these are things that we are trying to take pride in.

Our Association -- I have said that. We are strictly regulated by the Regional Home Day Care Administration of Waterloo and yet we are paid less than the private sector in our area. We receive -- we got a raise of 50-cents per day. Now, we are making \$13.50 per ten-hour day and those in the private second are paid \$15 per ten-hour day in our region.

We ask: Are subsidizing distributor the government to monitor us. Are we supposed to pay for this service that comes around and regulates us. In the job re-entry program in our area, the parents are currently allotted \$16 per day for child care and we have no way of knowing if they are pocketing the extra \$2.50 plus the money they save when we feed the child.

In our region we currently provide service to 65 per cent of all total subsidized day care, yet we receive less than 40 per cent of the total day care dollars spent in our region. Each year day care administration holds our rate increase to 4 per cent as per government instructions.

Currently a 45 per cent increase in payment to providers in the regional budget had more to do with the expansion of service than payment by enrollment. Each year providers work harder due to increased level of service, take more responsibility due to increased regulation demands by administration and are paid less, held at 4 per cent while our costs, food and insurance, soar to over 8 per cent.

Day care administration chooses to regulate and monitor our services strictly each year and yet refuses to recognize us as having any closer relationship; i.e., dependent contractor and we find there is little or no incentive to provide service for the government -- little or no incentive to work for the government since there is no motivation: If we improve ourselves, get courses, or go to

other things, first aid courses, that sort of thing.

We recommend: Providers be adequately trained to provide services and be given recognition financial and emotional for such training, providers be paid more than the private sector for facilitating and instituting the day care regulations, an incentive to adhere to the rules and, three, if providers continue to be strictly regulated by the Day Nurseries Act the government should recognize some form of closer relationship; i.e., dependent contractor status. Give us the minimal incentive to provide service for these children who we do care for. Please stop punishing us financially for wishing to improve their lot by submitting to the will of the government.

Finally, if the Provincial Government is thinking of extending regulations further into the private sector in informal care, they should consider the lessons learned from our experiences. We recommend they be prepared to pay more for regulated home-based care or make the regulations more flexible and accommodating to home environment.

And in conclusion I would like to say that if you are talking dollars and cents which I found out how much I made last year which was \$3,400, that was for 270 episodes of care or 1,404 hours of care, and if you take out the meals at \$3 per day, that brings me down to \$2,590 and I worked for those 1,400 hours, that is approximately nine months, so I am not working part time.

Mr. Chairman: Questions?

Mr. Jackson?

Mr. Jackson: Thank you. This is a very interesting brief and the first of its type to appear before us so perhaps you could be helpful. I am trying to understand more clearly the relationship you have with the Region of Waterloo?

Ms. Wasilka: They contract services to us. That means, that if they have children that require subsidized care, they come into our home and they have a check list which they do quarterly. They come in and they monitor us, go through the check list, nutrition, health/safety standards and then they come in monthly to talk to us about how things are going, that sort of thing.

One of the regulations that, they asked me to move my smoke detector from the corner of the room to the middle of the room. One lady was told she could not use a rectal thermometer, that sort of thing. We are quite highly regulated I would say and this varies from section of town to section of town and from region to region.

Mr. Jackson: And the region pays you directly or the child's parent pays you direct?

Ms. Wasilka: There is a subsidized cut off level and after that point the parent pays partial payments, but I have never had a parent who paid me.

Mr. Jackson: So all your children...

Ms. Wasilka: All my children-- I can take in private kids as well.

Mr. Jackson: I was going to ask that next. So you can have a mix?

Ms. Wasilka: Yes. It is almost imperative for me to have a mix because I do not live near an Ontario housing unit, I live downtown.

Mr. Jackson: Okay. So I am still not clear as to the referral from Social Family Services, they pay the cheque directly to the family and then the family provides you or they pay you directly?

Ms. Bleackley: Directly to us.

Ms. Wasilka: That amount per rate, it is over so many hours and then we get a rate per hour and it is deposited into my bank.

Mr. Jackson: Okay. Well, you said they provide \$16 of which you only see \$12.50.

Ms. Wasilka: That is on the job re-entry program.

Mr. Jackson: All right, but that is not on the normal referral?

Ms. Bleackley: No, we get \$13.50 a day.

Mr. Jackson: You get \$13.50 a day.

Ms. Wasilka: You see, if I have a child in my care and the mother goes into the job re-entry program from say an open-door program where she is getting education and she says to me, I am prepared to pay you now myself, she can say that she is paying \$16 and only pay me \$13. That is my understanding of how it could work.

Mr. Jackson: It is interesting. And how many child care placements would there be in the region on this kind of...

Ms. Wasilka: Thirteen hundred and they are going to expand that by 15 per cent, I believe, this year.

Mr. Jackson: What are you in competition with within the region?

Ms. Wasilka: The centres, basically, for subsidized children.

Mr. Jackson: So these are non-profit or these are commercial operations?

Ms. Wasilka: I believe they would be mostly all non-profit, mostly municipally-run day care centres.

Ms. Bleackley: We do have a problem with the private people as well because their rate of pay is going up higher than ours. They are now being paid like \$15 a day which is what they are asking from parents privately and under a licence system we are only getting \$13.50, so private people, what I call private people, ones that are not regulated, are actually starting to get, more their level is getting beyond our.

Mr. Jackson: Private people is if someone puts an ad in the paper...

Ms. Wasilka: That is correct.

Ms. Bleackley: That is correct.

Mr. Jackson: Okay, so not a private operator and the wages they are paying their E.C.E. worker?

Ms. Wasilka: No.

Mr. Jackson: You are referring to the next level...

Ms. Bleackley: Next door, the woman...

Ms. Wasilka: The lady next door.

Mr. Jackson: Okay. Thank you.

Mr. Chairman: Mr. Cooke?

Mr. Cooke: A couple of brief questions. How many children would you be allowed in your home?

Ms. Bleackley: We are allowed up to five children and that is including our own children under the age six -- or actually the Region of Waterloo says under the age of ten.

Ms. Wasilka: That varies as well. We are not really sure. In some instances they say five at one time and in some instances they say enrollment of five and if it is enrollment of five, you can have one in the morning and two

over lunch and then two late into the evening. We have cases where there is ladies getting up at six and working until midnight.

Mr. Cooke: And very few, if any, of your colleagues or ourselves would have your E.C.E. training from the local college?

Ms. Wasilka: You are looking at one.

Ms. Bleackley: There are a lot.

Ms. Wasilka: There are very few, yes. Most of them are mothers, but again if I have a child -- a problem with a child and let's say it has a rash that I do not know what it is or he has bit the little kid, that child-- sometimes I find other providers who have been doing it for 13 years. If I am having a problem relating to a parent, I find that I get more practical advice from the other providers than I do sometimes from the visitors who are, say, teachers or E.C.E. teachers because our situation is different. These people are coming into our homes.

Mr. Cooke: I am just looking at some of the factors that may contribute to the fact that there is different rates, that the other major factor I would assume would be capital cost, that there would be no capital cost associated or very little capital cost associated with your facilities since it is your home?

Ms. Bleackley: Are you talking about operating costs?

Ms. Wasilka: He is talking about toys and stuff like that.

Mr. Cooke: I am talking about you do not have to build a facility or pay rent.

Ms. Bleackley: Okay, but we do -- in the Region of Waterloo, this is a problem that we have as well, we do not get equipment or materials to work with. Like, this all has to come out of our own pocket, where in other parts of the Region the day care agency will supply equipment like playpens, high chairs, car seats, materials.

You see, like this is the difference that we are experiencing with the Day Nurseries Act is interpretation of the Act itself and that one region might interpret it one way saying, well, yes, we will give our providers this and another region will say, we do not have to pay for this, you know, and it is: Who is to pay for what. And that is a problem with the Act. It should be simplified, the Day Nurseries Act to make it easier to read and that providers can...

Mr. Cooke: But you are not trying to make a case that you should get exactly the same rate as one of the municipal centres or non-profit centres or private centres?

Ms. Wasilka: Not at this point, but sohow the payment to providers has to be improved because in our area we feel that our services are being used more because we are cheaper to put it quite frankly, and there is a demand for more day care so they are pumping more children into our specific type of day care in our region and we are afraid that they are going to push, they are not going to get the quality of care because they are going to have to ask someone who may be a little bit uncomfortable with asking because they need somebody in that specific area.

Now, I am not sure if that addresses the question you were asking.

Mr. Cooke: I mean, I have certainly heard that this type of informal care does not just occur in your region, of course, it occurs across the province and certainly quality is one of the major concerns because there are so many and they are very, very small and it is impossible to properly regulate and guarantee quality.

Ms. Wasilka: If they got the parents -- and I really believe that a parent knows when his child is getting quality care. Okay, I have had personal conflicts with a parent, but I think they know if the child is happy to come and basically he is happy to leave and see you later and if the parent gave some sort of -- if they had a list of some sort of a reference to give the parents after each child has left my care, that I could be judged by the parents and by the children, I would find that judgment enough.

Mr. Chairman: Mr. Jackson you had a brief supplementary?

Mr. Jackson: Yes. It is with respect to the concept that Mr. Cooke is exploring. Do you consider yourself to be a private operator under contract to the region?

Ms. Wasilka: No.

Mr. Jackson: What do you consider yourself then, because by definition what I have heard too you are a single proprietor providing a service and, therefore, are there any tax implications to the portion -- of you earning an income from a portion of your home and it is affect on your capital gains?

Ms. Wasilka: We get a lot of good tax exemptions, there is no question about that, but there is no question in my mind that every single one of those is earned.

Mr. Jackson: I do not want you to consider that I am trying to abate you in any way, I am just curious, either you are a business entity in the eyes of the law or you are not, that is all I am trying to establish, and I think for purposes of this committee's examination, we have to look at you as a private operator under contract. You are free to take directly from a child without subsidy and then you can obtain a subsidy and Mr. Cooke was pursuing a line of questioning and I just wanted to make it clear for the purposes of this committee that we have to perceive of you as...

Ms. Wasilka: As a small business.

Mr. Jackson: As a small business. And you may be uncomfortable, you may feel that that is warranted, but I just -- I am trying to get a perspective on that, that that is the context in which we have to look at you and the impact.

My question flowing from that is: It has been suggested that subsidies be phased out after three years which would really eliminate your program, you know, for all intents and purposes, unless the municipality chose to use municipal dollars for the subsidy and waive any claim for provincial or federal funds.

How do you feel about that?

Ms. Wasilka: I was not aware of that.

Mr. Jackson: It was a recommendation yesterday from the Toronto...

Ms. Wasilka: If you take a look at the regional budget and look at the amount of money that they are spending to service 800 children and try to put those in centre cares, in centres and the cost to build the facilities and the cost to the parents and to the government, I don't know when you'd be able to afford this, I do not know when you would be able to afford it.

Mr. Jackson: Well, I am not going to argue with that. That is the basic argument which is being conveyed about the difference between can the public sector come up with all the capital necessary to expand the system, or should we rely on private sector configurations of which yours is one and the gentleman who was here first is another type of configuration.

Ms. Wasilka: Are we really private, if we are regulated by an agency that is licensed?

Mr. Jackson: Well, so is a private operator. He falls under the Act and he is regulated and if he gets a

purchase of service agreement with his municipality to take referrals from Social Family Services, then in fact he has to disclose his accounting and all of those factors as well.

But I guess the point I was really trying to establish here is that if we make modifications to any system where it is private ownership you would be embraced in that context and it is in that context I wanted you to think about it because you may wish to take a different position as an association in order -- because your very survival may be hinging on it if you are...

Imagine, for example, that you are without any contract with the region, that you are only able to operate privately and then you may as well -- you do not need regulations because you just can take what you refer to as your private marketplace, the mother who takes in three kids and it is a separate arrangement between the parent.

Ms. Bleackley: But we have a lot more providers legal with the licensed system to go private because the money is better at this point. I mean we had one provider say to us not too long ago, I can make \$400 staying with the region or \$600 privately. Which way do you think she went? She went private.

Mr. Jackson: You are caught in a vice from the government at top and the marketplace underneath and you are going to be squeezed out completely. That is what I sense.

Ms. Bleackley: I personally just take subsidized children because I feel there is a need to have those spaces, but, you know, they are saying that we cannot have both.

Mr. Jackson: Thank you.

Mr. Chairman: Thank you very much.

I just want to say just for my own clarification, when you negotiate with the region it is on a negotiated basis in terms of how much you get? It is not a fixed rate, is it?

Ms. Wasilka: We have been going before the region, I have been on the negotiating team since-- for two year. It is not really a negotiation.

Mr. Chairman: Well, but in essence what it is is a sum that is arrived not by reason of any anything etched in stone, it is a contract with the region?

Ms. Bleackley: Well, it is to stay within a budget now and you are looking at 4 per cent. You know, they want to stay within 4 per cent for everything.

Mr. Chairman: I realize that. The point I am trying to get at it is them bargaining with you, that is how the rate is arrived at, okay.

Ms. Wasilka: Not really. It is like they say we will give you 50-cents, take it or leave it, quit if you do not want it and get rid of all the children that you have already become attached to.

And that is one way, is you take in a child that you have at nine months old, you get attached to that child, you take him into the family, parents nights, you have him in the evening a lot of times when he is sick and you get attached to them and they say, this is the rate, take it or leave it. What are you going to do?

Mr. Chairman: What I am getting at is that is why it varies from region to region, because it is a negotiated rate between the region and the providers?

Ms. Wasilka: That is correct. I would like to see if it is at all possible that there be some higher form of appeal, that if the providers are not happy with what is being negotiated regionally, if the region has other things, priorities in their heads, roads or waste disposal or whatever, that there be a higher form of appeal that we could appeal those rates.

Mr. Jackson: As long as you are a private citizen contracting privately you will never be able to achieve that because of the contractual relationship that you have. Basically it is an agreement with an individual which you have established in a collective even environment and there is no formality beyond that, no legality beyond that for you to negotiate.

Ms. Wasilka: That is true.

Mr. Jackson: It is just simpler for the region to negotiate with all of you as a representative body, but your contracts are on an individual basis...

Ms. Bleackley: Well, they are all the same contracts.

Mr. Jackson: ...than negotiate with each and every one of you individually.

Ms. Wasilka: That is true.

Mr. Chairman: Well, I want to thank you very much for coming forward and we appreciate the information.

As Mr. Jackson has indicated, this is the first presentation we have had of the particular type of service you provide. It is interesting to have this.

Ms. Bleackley: Excuse me, Mr. Chairman, but I want to point out something to you in saying that not every region negotiates with the providers on what the rate is.

I have worked in two different regions and I was never consulted before in the Ottawa area as to what our rate of pay was going to be. The agency negotiated with the region but there was no provider asked as to what do you want to be paid this year.

Mr. Chairman: They make an offer.

Ms. Bleackley: No, they just say this is your rate and that is it.

Mr. Chairman: That is what they are making is an offer and you accept it by providing the service?

Ms. Bleackley: That is right, and it is, you know, take it or leave it.

Mr. Chairman: Thank you very much.

Ms. Wasilka: Thank you.

Mr. Chairman: We are adjourned until two o'clock at which time we will consider the draft report.

The Committee adjourned at 12:10 p.m.

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SELECT COMMITTEE ON HEALTH

COMMERCIALIZATION OF HEALTH AND SOCIAL SERVICES:
CHILD CARE

TUESDAY, MARCH 31, 1987



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Baetz, R. C. (Ottawa West PC)
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Cordiano, J. (Downsview L)
Hart, C. E. (York East L)
Henderson, D. J. (Humber L)
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Mitchell, R. C. (Carleton PC) for Miss Stephenson
Pierce, F. J. (Rainy River PC) for Mr. Andrewes

Clerk: Deller, D.

Clerk pro tem: Manikel, T.

Staff:

Fooks, C., Research Officer, Legislative Research Service

Witnesses:

Individual Presentations:

Rothman, L.

Condon, E.

From the City of Toronto:

Beach, J., Planner, Human Services Section, City Planning and Development
Department

From the Ottawa-Carleton Day Care Association:

Somers, R., Past President

LEGISLATIVE ASSEMBLY OF ONTARIO



LEGISLATIVE ASSEMBLY
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13 April 1987

NOTICE:

Please find enclosed a **Corrected** copy of the
March 31, 1987 - #H-15 - Transcript.

Page 11 to 16 were missing in the first copy
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Select Committee on Health

LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON HEALTH

TuesdayMonday, March 31, 1987

The committee met at 10:20 a.m. in room 2.

COMMERCIALIZATION OF HEALTH & SOCIAL SERVICES:
CHILD CARE

Mr. Chairman: Good morning and welcome to winter. We have a couple of items before the first delegation at 10:30 appears and the first one is that the second group on your list, or the eleven o'clock group, have asked for some assistance in terms of expenses.

It has been suggested, and I do not know whether the committee is in agreement with it, that we would contribute to the air fare round trip from Ottawa of one member of that delegation. Is that acceptable to the members?

Mr. Johnston: Are there other requests?

Mr. Chairman: We have had a couple others which we discussed on the last occasion, Richard, and I cannot recall what ones they were.

Mr. Johnston: Have they taken the same approach? As long as they are consistent that is all that I care.

Clerk of the Committee: Children Together Association.

Mr. Chairman: I think so. The Children Together Association and they are from where...?

Clerk of the Committee: Ottawa.

Mr. Chairman: Ottawa. We agreed to that.

Clerk of the Committee: I am sorry, that is from Kingston.

Mr. Chairman: I am sorry, from Kingston.

Clerk of the Committee: And it was air fare for one person from the CUPE local from Ottawa.

Mr. Chairman: Okay. So we agreed to the mileage for the people coming from Kingston because they were driving and to the air fare for one person from Ottawa with the CUPE local.

What did we do on the other one? We had another one

there?

Clerk of the Committee: That was from Montreal.

Mr. Chairman: We decided not to. We had another request from Montreal. We decided not to hear the delegation but they sent us a brief.

Mr. Johnston: Well, that seems to be consistent, as far as I am concerned.

Mr. Chairman: A consensus among the members that we would do it? Do we need a resolution?

Mr. Johnston: Yes. There should be a motion on that.

Mr. Chairman: Yes. It is moved by Mr. Johnston that we cover the expenses of one round trip, I guess economy flight, from Ottawa to here and back with reference to the Ottawa/Carleton Day Care Association delegation.

Those in favour? Carried.

The second item that we can deal with possibly, although I see Mr. Cordiano is gone, we require a Vice-Chairman. We tried to do this the last time and nobody wanted it.

I am suggesting that maybe Mr. McKessock might take on that role since Mr. Cordiano is with PA for the Ministry that we are now discussing and Dr. Henderson has indicated he did not wish to serve as Vice-Chairman.

I wonder, Mr. Cordiano, if you would nominate Mr. McKessock as Vice-Chairman and if he is agreeable to it...

Mr. Cordiano: Sure.

Mr. Chairman: ...we can fill that position, that well-paid position of Vice-Chairman of this committee.

Do you move that?

Mr. Cordiano: I would move that.

Mr. Chairman: Mr. McKessock, are you prepared to serve in that capacity?

Mr. McKessock: I suppose. Is this until the duration of the committee or how long is this?

Mr. Chairman: Until the duration of the committee, the Select Committee.

Mr. Johnston: At this stage you could consider it until the house comes back, rather than beyond, just for what we are dealing with now.

Mr. McKessock: Okay.

Mr. Chairman: Those in favour of Mr. McKessock? Any other nominations?

Those in favour of Mr. McKessock as Vice-Chairman?
Carried.

That is it, I think.

Mr. Chairman: Oh yes, the Clerk has drawn to my attention, on the general list that we were given we had two groups that really do not fit in to any category specifically.

If you have your list there, the first one is Pran Manga, Research Professor, National Health Research Scholar, University of Ottawa. He is requesting travel expenses as well and the Medical Reform Group, Mr. Gordon Giuyatt from McMaster University, Health Sciences Centre in Hamilton. And before bringing this to the committee's attention, I had suggested that perhaps the two of those might be put together since they seem to be at least on the surface somewhat similar, but I am open to committee's views on that.

Mr. Johnston?

Mr. Johnston: What is the name of the first person again?

Mr. Chairman: It is Pran Manga.

Mr. Johnston: Oh yes.

Mr. Chairman: He is a Research Professor, National Health Research Scholar.

Mr. Johnston: He has appeared before the committee before, not this committee but before Social Development on other matters dealing with research. What part is he interested in dealing with, do you know?

Mr. Chairman: Well he says see Exhibit 13. Do we have -- let's see what Exhibit 13 says. Anybody have 13 with them?

Mr. Mitchell: Just looking for it now.

Mr. Chairman: Well actually, no, it probably would have been given to the sub-committee I think it was, in

fact.

Mr. Mitchell: Yes.

Mr. Chairman: And we decided which groups were here.

The clerk is going to get a copy of 13, that will let us know what this gentleman is here for.

Mr. Johnston: You are saying you are trying to fit them into the same time frame, what were you talking about? Do you have an idea in mind?

Mr. Chairman: Well, we might be able to slot them in. I do not think the clerk has checked with them yet as to when they are available, but in terms of time we could probably slot them in perhaps on the 13th of April. We have the Child Care Report -- sorry, that is a Monday so we are not starting until two.

Perhaps we could slot them in on the 14th in the afternoon. We are going to have a day and a half to consider the interim report.

Mr. Johnston: I do not think that makes any sense.

Mr. Chairman: Or, because we are not considering hospital until the following -- 15th and the 16th, we could probably slot them in the 16th. We only have a morning session and that -- I would certainly think the Medical Reform Group would fit in there if I understand why they are coming.

Mr. Johnston: Well, what is their purpose? Is it to come for the second matter or for the first matter; for the Day Care?

Mr. Chairman: No, it is hospital management, their's certainly is.

Mr. Johnston: Oh fine, okay.

Mr. Chairman: Because they are under that grouping and so is Manga, hospital management.

Mr. Johnston: Oh he is.

Mr. Chairman: Do you have the dates for them?

Clerk of the Committee: No, we have not contacted them at all.

Mr. Chairman: Maybe the 16th, we have only got a morning session, we could...

H-5

Clerk of the Committee: Mm-hmm.

Mr. Chairman: If the Clerk can get them in on the 16th, would that be agreeable to the committee members?

We have a consensus on that, so maybe you could check on that.

Clerk of the Committee: Mm-hmm.

Mr. Chairman: That seems to be all we have until the Mayor gets here. He has probably been slowed down by the lack of plowing on the roads.

Mr. Mitchell: He will be on his phone calling his road crews I am sure. No, they are Metro, aren't they?

Mr. Chairman: All right. The clerk tells me that the group from Ottawa, the eleven o'clock group, are at the airport trying to get a cab so they may be a little late.

Mr. Mitchell: Yes, quite understandable. That is quite understandable. Rosemary will be checking with...

Mr. Chairman: Maybe we could drive out and get them?

Mr. Mitchell: I will let you go. Even for Rosemary I would not do that.

Mr. Chairman: I think we can go off the record. There is not much point in Hansard recording our little tete-a-tete.

---Upon recessing at 10:30 a.m.

---Upon resuming at 10:55 a.m.

Mr. Chairman: In the true biblical sense we have gone out into the highways and byways and we have come up with a group who would like to address us, so we have invited them in here, and if those people who wish to address us would like to come forward and identify themselves and...

Mr. Johnston: You have got to get their real names though that is what I want to know.

Mr. Chairman: They just got out of a press conference on Day Dare in the media studio, so...

Mr. Johnston: Do you have any copies of the stuff that was given out at the press conference with you? That would be great if members could see that.

Ms. Rothman: Yes, we have some.

Mr. Johnston: Do you have any of the statements? I have one. Who was I showing it to?

Mr. Mitchell: Richard has been working hard for this committee, I gather.

Mr. Johnston: Well, I will probably just change and have to meet somebody, so...

Mr. Mitchell: Well, that is true, I totally agree with you.

Mr. Chairman: We are presently on Hansard so one voice at a time or our operator will wind up with an Excedrin headache.

The Clerk is going to make some copies of the particular information. I should explain for the members of the committee why the Mayor, of all the people of Toronto, is not here. He is in Montreal. Apparently there was some mixup in terms of this being a definite date and a tentative date. We had assumed it was a definite date, but I understand that there may have been a miscommunication there.

So we cannot really wait for him to come back from Montreal, so perhaps you could start and the Clerk will provide us with the information at a later date.

Would you like to identify yourselves for the purposes of Hansard so you can be etched in history.

Ms. Conden: My name is Eileen Conden and I really did not think I would be here this morning.

Mr. Chairman: We did not either.

Ms. Conden: Because maybe I would not have been, but I am a parent and I would like to speak to the non-profit/profit issue around child care.

I have two children. I have a child that will be two next week and a four year old and I have just found that the last five years looking for care for these children has just been horrendous and at this point I have luckily got my oldest child part time into a day care centre and the two year old has to go to a babysitter which I am really unhappy with.

Some days when I pick him up his diaper has not been changed or he is not that clean or he is not right on hand, she does not know where he is in the house. I mean, it is just a really bad situation.

Mr. Chairman: It is all right, Eileen. Just relax.

We are all very friendly people here. Are you from Toronto?

Ms. Conden: Mm-hmm, yes I am.

Mr. Chairman: Maybe if you pour yourself a glass of water there.

Ms. Conden: It is just that when you have to leave a two year old in a situation and you know it is not the best situation it is very hard, but hopefully he will be into a day care centre soon and I want you to be aware of that, that this is the kind of burden that women in particular have to live with.

So anyway, when I was looking at day care centres, getting back to I guess the issue at hand which is the profit versus non-profit, I went to a day care too actually. I think one was on Spadina Road, Edgewood Manor, I think it is quite an infamous setting or building. It was a summer day, I walked into this old dreary building on Spadina Avenue. It was, you know, quite a dismal place. I mean, my thinking was, God, it is like the 19th century in here it was so dark and reminded me of Dickens.

Anyway there were three television sets in that -- I think there were two or three anyway, it was noon, just before lunch and in the first door there was two rooms and there were -- I cannot remember the number of children -- there were at least 12 little children cowered around a television set. I mean this was just incredible to me, that this was supposed to be a day care centre, sort of enriching children's lives and so on, and there was one caretaker there. There were hardly any toys in the place. I mean, it certainly was, to me, looked like a very deprived environment. They had the menus up on the wall and they actually had Coke on the menu.

Mr. Chairman: Coke?

Ms. Conden: Coca-Cola, yes. Not cocaine, Coca-Cola. I mean they might be making profits but I do not know if they are making that much.

But anyway I went up to the second floor and there was another television set. I mean this is a bright sunny day, there was no light in the room, there was another gathering of children around a television set. I mean, I just could not believe it. And so I cannot remember the amount of staff there. Apparently the cook was doubling up as a cook and also a caregiver and, I mean, it was just a very deprived environment.

I know if I was a parent and I was forced to put my child into a situation like that, well I would be just as emotional about it as I am about having to put my two year

old in to, you know, a babysitter, a woman down the street which to me is no choice at all.

Anyway, after I looked at Edgewood Manor, I went to George Brown College to look at the centre there and, I mean, that was like a night and day experience. I mean, George Brown was such an enriched environment; high quality care, I mean there was just so many things. The different age groups, there was so many things for them to do, for their development and the staff seemed to care and it was just the whole atmosphere of the place.

I mean, at Edgewood Manor it was just a really heavy, heavy kind of depressing environment and the children were very subdued, but at George Brown College, I mean, it was just the kind of place -- even if you were against day care, you could see that it would be an enriching experience to put your child into that setting.

And so I think that is basically all I can say, is that we have to give our children what I saw at George Brown College and when, sort of, the Prime Minister says we have to have choice, I do not think it is a choice for a parent to have to leave their children with the woman down the street and I do not think it is a choice for parents to have to put them into an environment like Edgewood Manor, I mean, the only choice should be a really high quality choice.

Mr. Chairman: There was a larger number in your group. I wonder if any of them would like to add anything to what you have said.

Okay.

Ms. Rothman: I am Laurel Rothman. I guess I am really going to be speaking as an individual. I probably should explain that I have been involved in day...

Mr. Chairman: Sorry, Laurel, could you repeat your name for Hansard. I do not think they picked it up.

Ms. Rothman: Sure, Laurel Rothman.

Mr. Chairman: And you are from Toronto, Laurel?

Ms. Rothman: I am from Toronto. I guess I probably should explain. I have been involved in the day care field in a number of ways for -- let's see, my oldest is 15 -- about 15 years. I have three children; 15, 12 and 7. I am still a day care user, have been on and off.

Listening to Eileen reminded me of one of the earlier situations when I also had my youngest child in a situation with a neighbour who I thought in fact was probably going to give okay care. This was when I was new to Toronto, knew

nobody, had no family and another neighbour I remember happened to tell me that my child had been left alone outside, he was about 6 months old, in a carriage without any kind of a harness or anything. He could have very easily stood up or gotten up -- he was actually older than six months old -- fallen out or whatever and my friend was so concerned that she finally went around and found the caregiver who, of course, was quite chagrined.

And I think again, like Eileen, I do not think that is a choice for people and I think that probably in lots of communities across Ontario parents are faced with the dilemma, I would not call it a choice, of what to do if you need to find employment and you need to find child care.

I would like to add a couple of comments about the profit and non-profit issue. I guess I should also add that I am quite familiar with the day care centre that Eileen described. I also happen to know -- because I did a little research on it-- that the fees in that day care centre were almost as high - I wish I had the numbers in front of me - they were as high as the centres in the surrounding area that were non-profit. I later checked and found out in fact that the salaries - I happened do a weekend course which included the supervisor in that centre - and the salaries in that centre are significantly lower than the non-profit centres in the area. I guess all that we are saying is we are elaborating on the number of the facts that you are seeing in the briefs that are probably coming by, but I guess you really described the human impact of what that means.

I would like to make one other comment, just very briefly. Certainly personally it is my sense that we are facing really a pivotal decision in Ontario. I think there is going to be more public funding, certainly this government and the federal government are talking about substantial more funding of some sort, which can be used somehow directly or indirectly in child care and in Ontario we are talking more directly about money to services.

And I think that it is certainly my personal opinion that if we are really talking about developing a public service that families can find in communities across Ontario that they can rely on as being safe and educational, then I think the first responsibility is to develop that public service. And certainly from my perspective and my involvement, public service does not have room for -- there is not room for the profit incentive in public service. And so it certainly would be my personal recommendation that no public dollars go toward commercial child care.

And I think that now we are at the time where we really have to make a tough but important decision to go one way or the other because otherwise in a few years we will

have commercial centres springing up as they have in other jurisdictions following the money.

Actually, I will give one more horror story that is not a direct, personal one but I was speaking with a colleague who used to be a licensing inspector in Alberta and in fact I encouraged her to come to this committee - I do not know if she will garner her energy and nerve and do that. And her job in that, she is now back in Toronto and in fact her job was to license and regulate day care centres in Alberta, whereas you probably have heard from other deputants or if you have not you will, substantial amounts of public money go to both profit and non-profit day care centres, you know, as much as \$12 a day per infant space.

She described a number of situations in which there was also no role for parents as well as there being no accountability for where the money went and there are few public facts available around salaries. The informal opinion is, I guess the grapevine or the market opinion is that average salaries in day care in commercial centres in Alberta are between four and five dollars a day and that in many situations the quality of care is not unlike what Eileen described.

And, in fact, in the one centre that was described to me parents were not allowed to go beyond the front door. They would press a buzzer and the teacher, child care -- early childhood educators would bring the child to the front door to meet the parent and when a parent tried to object to this there was, first of all, nowhere else for that parent to go in that particular community and also they found that it was not in any way against the regulations.

I later found out, someone said to me, it is probably not against the regulations in Ontario either, but I think that perhaps that is something we should look at.

I guess I would just only want to personally go on the record as saying that I think that there would be tremendous problems to move toward supporting a sector that certainly appears in many ways not to provide, not certainly to have the incentive to provide a high quality of service for children.

Mr. Chairman: Okay. I have one person on the list for questions at the moment, Mr. Mitchell?

Mr. Mitchell: Well, primarily my question started with the first one to speak. I am sorry, I missed your name?

Ms. Conden: Eileen.

Mr. Mitchell: Eileen. You did not, in your

presentation, make a comment one way or the other, although it was something quite clear that you were speaking against funding for-profit day care facilities. Of course, Laurel you made that quite clear as you came and took the opportunity to speak, but are you totally committed or totally convinced really?

I mean, I keep hearing this kind of blanket statement made from the witnesses we have heard so far that those that are for-profit are not good centres and I take exception to that because I know many that are. I have visited them and so on and I find that a pretty harsh kind of a statement or idea to be flowing.

Ms. Rothman: I suppose probably a more professional and thorough approach would be to say that as a sector I think that we have some facts that tell us that commercial child care is a little lower quality. I think you are probably right. Obviously it is not all black and white. All non-profit centres are not as high quality as we all would like them to be and all commercial centres are probably not as depressing and lacking as certainly the situation that Eileen described, but I think if we are talking about - as Mr. Sweeney and the government has to our pleasure - expanding quality services for Ontario families, it is certainly my opinion that we want to aim that in the best direction possible.

I was mortified to read in that federal report for the first time I think anywhere from certainly my reading and knowledge, that the Feds are talking about giving money to start up commercial care, those small start-up dollars for starting new spaces could go to non-profit or commercial day care centres. I think it is my sense that if people want to run commercial day care as a small business that is their choice, but I do not think that public dollars should be expended in that direction.

Mr. Mitchell: Well, if I may respond to that. The municipality I come from, we in fact provided seed money for operators to come in and set up day care programs because we knew we would never get the types of -- or the spaces that we needed if we waited for municipal day care to be provided and in fact the ones that have been provided in are municipality are the ones that I visited and I find they well run with very caring people running them.

I do not know whether you are familiar with the Ottawa scene but, for example, the young lady by the name of Kathy Yau who is very involved in day care who runs an excellent operation with her confreres.

Am I to gather from, I guess your tone, that you really are supportive of the universal day care theme?

Ms. Rothman: Yes, certainly I personally would support the development of that system over a period time. I do not expect to see eleven billion dollars in one year. I am talking about a graduated, comprehensive, long-range approach.

Mr. Mitchell: How far do you think, using that statement - I am playing a bit of a devil's advocate here - how far do you think that theme of universal day care, do you think the tax-paying public, I am talking about those with no family, those that are seniors and so on are going to say that they can afford those types of programs which are obviously going to be extremely expensive?

Now, do not get me wrong, I agree that day care is a necessity, I am not sure that it necessarily always gets into the right hands, that is an aside, but how far do you think the taxpayers - those who will not use the services - will go before they rebel?

Ms. Conden: Well, there is a public education system that people support, that not all people have children.

Mr. Mitchell: I am sorry?

Ms. Conden: Public education, people pay tax moneys for that and they do not have their children in there.

Mr. Mitchell: They are even arguing about that today.

Ms. Conden: 20 per cent of Canadians go to university and the millions of dollars that are put in at that end, you know.

Mr. Mitchell: I guess the point I am coming from is great power is growing and there is a lot of seniors out there today who are coming to my office and I am sure they are coming to other members' offices and saying: Look, it is going too far. I have no children in the educational system and yet half of the taxes I pay municipally are going to education. Why? And they are going through all of this sort of thing when, in fact, this is what I mean. I have even had, I am being honest, not to a great degree, but I have had it from seniors, why should I -- if universal day care comes about, why should I have to pay for that? I am not putting a load on the system, why should I have to pay for it?

Now, as I say, do not get me wrong, I acknowledge the need for day care but I have to ask you: How far do you think the public will go and how quickly do you think a government could respond to that type of thing? You commented that they cannot do it in one year, obviously, but how long do you think it would take them to be able to build up and acquire the facilities and so on to provide this sort

of service you are talking about?

Ms. Rothman: Well, we have had a lot of research on that in the Katie Cooke task force, I think it is going to take time, but certainly Mr. Sweeney has announced an intention - where did I hear him say - to double space this in five years. Perhaps that is not the right number, I am not sure.

I think that what we really want to see is concerted planning toward a range of services, you know, that people would be able to use over a period of time, funded in the best interest of families.

Mr. Mitchell: My wife and I, we have five children, we never once in our lives used day care or babysitters. We chose to look after our children in our own home. Now, as a result I wound up holding down two and three jobs at the time to have the income necessary to support the family and I am not sure that was a good situation, but there are people like myself out there who also react and I make that more by way of comment. As I say, do not get me wrong, I quite agree for the need and the necessity for day care.

I am just trying to point out that there are people who we have not heard from in the past who are suddenly - and I raise the question of universal day care - if that ever comes about, we are certainly going to hear from and I do not think you should kind of expect that to be a quiet one. I think it is going to be a lot noisier than we think.

Ms. Conden: Then I think it is a social force. I mean, I do not think we could hold back the same way we could not hold back Medicare and the same way we could not hold back a public education system and excuse me, but your generation, I mean, that was the typical model for a family. Today that is not the reality. 16 per cent of families make up a traditional nuclear family in Canada where the wife stays home and the man goes to work. I mean, the number of single families is growing rapidly.

Mr. Mitchell: Indeed it is.

Ms. Conden: I mean, do we have a social service system in Canada or do you leave it to market forces?

Mr. Mitchell: There are people out there however that would reply to you that, yes, we should provide where need is proven.

Ms. Conden: Has need been proven here for day care?

Mr. Mitchell: As I say, do not get me wrong, I am not denying the need for day care, I am talking about the public response of people out there who we are in fact going to

have to contend with it.

Sorry, Mr. Chairman, to...

Mr. Chairman: All right, Mr. Mitchell.

Mr. Johnston?

Mr. Johnston: Thank you, Mr. Chairman.

The committee is struck with a task of trying to do something which no government in this country and certainly not in this province has ever tried to do before and that is to come up with some sort of rational consideration for why some things are done in a profit sector and why some things and some services are provided in the non-profit sector and why we have what has evolved into a bewildering mix of profit and non-profit kind of services within Health and Social Services particularly.

And within that you are going to hear a lot of confusion, just like you just did from my peer, from certain members in terms of the notions of what we are about and what the principles are that are involved.

In terms of the whole notion of universality, I think that the question of universal programs and how you define universal programs and what they are is another whole issue that we can deal with separately, if you like to.

In terms of how long it would take to get there, I would just say it has taken an awful long time for us to even get as far as we are at the moment on day care and to even have any minor recognition by these two parties in Ontario that it should be more than based on need and, therefore, on welfare and is a service which is required both in terms of participation of women in the economy and also for children to be able to make the best use of the education system that we have presently in place and will need to have in place as our society changes.

The questions I guess I would have for you on this basis are: You stated, both of you in your own ways, and Laurel I have heard from many times in terms of the various organizations and lobbies on our parties in the past. You expressed a preference for a non-profit model.

I wonder if you could go back a little bit to the philosophical reasons for that because at the moment we do not have a very coherent system in day care or in health care even. There are some areas which are totally within the non-profit sector and others which are mixed and day care is one where there is mix and it is about 50/50 in general terms at this present time.

What is it, in your view, about provision of child care services, as you see them now and as they will revolve over the next little while, that you think make it something which should be non-profit and, therefore, equalized with our basic health care systems or our education systems in Ontario as compared with a lot of the other mixes, Social Service systems which have a bit of both in them. And I wonder could you tell me what it is about the nature of that service itself which makes you think that that should be the case, that it should be non-profit?

Ms. Conden: I think, just looking at the old age home situation and the horror stories we hear about that, I mean the quality of food, the number of staff, and when you are providing a basic human service for children, it is labor intensive, you want to know that someone is not cutting back. I mean, if you want to make a profit on anything you have to cut back somewhere and I would not want my children to be going to school knowing that the bottom line was to make a profit.

So people are looking around trying to see where they can cut back and that usually means first that you cut back on the number of staff you have in a day care centre, it would be the quality of the food, the toys you get, the field trips you go on. I mean, I do not think a human service should be run for-profit. You are providing a human service and this gentleman here is talking about sort of the emergence of this great power movement and I guess I am one of them, so that I do not want to be in an old age home where the bottom line is profit. I want to know that my needs as a human being are going to be taken care of and I see old people defenceless and young children are also defenceless and I think as a society you have to look after that and, I mean, you cannot leave that to the labours of the market place. I mean, I do not think so.

Mr. Johnston: Can you add anything more, Laurel?

Ms. Rothman: Sure, I would like to add a couple of comments. I do not know if it would be helpful, if you want to take your yellow flyer or whatever colour you have in front of you, maybe we will talk a little bit about the economics of it. I probably should add, although I am not speaking officially, one of my jobs is to - one of my work jobs, my paid labour force work jobs, is to help to administer the City of Toronto Day Care Grant.

The City, as you may know, helps to supplement the salaries of non-profit day care workers and non-profit centres and really responded to community pressure in late 1983 where basically there was a real crisis of empty spaces with people not able to afford to use them. And so I have learned a lot about day care budgets and bottom lines and what constitutes surplus and what constitutes expenditure.

So in a typical day care budget, you want to talk about 52 children, I think we are talking 10 or 11 staff, 80 per cent, at least, of your expenditures are staff costs, the rest would be food, program supplies, staff development.

I should say when I include the 80 per cent, we include some benefits if you are lucky enough to have them, not many of them do but some of the centres in the City that have gotten a grant now use that to supplement employee benefits, and perhaps occupancy costs, although certainly that is a major problem for day care centres.

So at the the same time staff -- in fact what you are providing is a service, you are not making widgets or selling apples and oranges, so the need to attract and retain quality staff, trained staff is critical to a day care operation. I guess I should probably share that in going over these budgets what we see is that even at paying salaries of 14-, \$15-thousand a year some as low as 11-, \$12-thousand a year there is virtually nothing left over.

I suppose we should go into the other side, the revenue side which includes-- the way you set the budget is you usually set the salaries, your fixed costs if you have many would be the rent and mainly program supplies and salaries. On the other side what you are looking at is what parents are able to pay. Obviously that is a difficult one and varies from locale to locale. It also depends on what the Board of Directors in that non-profit centre has as some of its goals. I am trying not to ramble.

Most day care centres' revenues comes all from parent fees. There is no other support. Perhaps a small amount of fund raising here or there or community service grant from a local service club, that is the exception and not the rule. So we are looking at a fee for -- a user fee system and that you are all probably aware of. In some communities some of those parents will be paying part of that fee and another part will be paid by the municipality and certainly I guess we should say that Ontario has among the most -- what is the word - potential for the most generous subsidizing of per diems and that is one reason why salaries have been able to go up because in fact Ontario will recognize those costs, will recognize salaries going up to 17- and \$18-thousand a year, which are not great, but they are being to approach getting above the poverty line.

To bring it back into perspective, the main cost is salaries, that is the one in which you probably have the most control over and in a for-profit child care centre usually, from what I know and what I have been able to see, most of the cost cutting is done in salaries and we do have some documentation, the background paper for the Katie Cooke Task Force showed us that salaries are already on the

average 30 per cent lower in commercial centres.

If in 1987 the proposal to go forth with a direct grant as Mr. Sweeney has talked about, even if it is tied to salaries which is very difficult to do technically, I could go on and tell you how I do not think it is possible to do it on a provincial-wide basis. On a city-wide basis we are having a hard enough time. If you took that direct grant and you added it on, say you somehow were able to tie it to salaries, your salaries in commercial centres would still be far below those in the non-profit sector and, as far as I can tell, the profit margin would still exist, so you would be faced with a situation not really very different than what you have now.

I think that probably -- so my concern is (a) that those public dollars to commercial centres are, first of all, very hard to account for. It will be hard to ensure that they go where they should be going. I think my other concern in the longer range is you could envision the scenario that in three or four years say, the plan is that direct operating dollars will only go to existing commercial centres, so I could envision that in fact entrepreneurs who heretofore had not gone into the day care business would swoop on in and open centres in place where there aren't any.

One might argue that, you know, is it helping things? I would argue it probably would be -- what would be the word -- enlarging the supply of less than high quality day care which would be something I certainly would not want to support when I think there is some alternatives that could be done.

So what you would face yourselves with in the next three or four years, would be a situation where you would have a group of commercial operators who were receiving a direct grant and you would have a group of non-profit operators who were receiving a direct grant and you would have a group of new commercial operators who were not receiving a direct grant and would come knocking on your door to get the direct grant. We would then have what we have seen happen in Alberta, the burgeoning and strengthening of a commercial lobby that has very successfully fought off stronger training requirements and other kinds of regulatory mechanisms in that province which would improve the quality of day care and, quite frankly, we do have some history that along -- at the last time of changes to the Day Nursery Act in Ontario I was certainly aware that the Association of Day Care Operators of Ontario certainly made formal statements opposing the changes in the regulations in the child/staff ratios because it would be too expensive and I guess I would fear that that lobby would grow and become more influential in Ontario.

So those are some of the reasons why I oppose enhancing the commercial sector and I probably should add that I think it is a tough decision and I think, however, the decision has to be more comprehensive. I would have to go on and personally say: no new purchase of service agreements to commercial centres as well, instead you put that money into building a non-profit sector the way we build co-op and non-profit housing in various regions of the province.

Mr. Chairman: We have a few other questioners and there are very substantial answers on that.

Mr. Johnston: Just a couple of things. I gather that you see the present juncture of the federal initiative that we have just seen in the last day or so and the provincial announcement that we have had by Mr. Sweeney of late as indicating a potentially new direction which could enhance the commercial side of things and, therefore, switch what is presently the balance that we have in the province. Am I right on that? You are nodding.

Ms. Rothman: Yes, I sort of did not mention that, but certainly that is a real fear.

Mr. Johnston: And this is a very crucial time for us to be looking at this particular matter.

One other thing I was going to ask. Oh yes. One of the arguments that is always raised from the other side which I am sure is in the minds of the provincial government and federal government, provincial government Liberals specifically, whose policy was never in this direction before and has switched to being in favour of direct grants to the commercial sector and expansion of the commercial sector and the Conservative Government of Canada and Ontario's perspective having been one of wanting that kind of thing...

Mr. Cordiano: That is not true.

Mr. Johnston: Oh yes, it is true.

Mr. Cordiano: In the commercial sector, we have not stated that as a policy.

Mr. Johnston: If you give a direct grant, Mr. Cordiano, to the commercial sector you are now moving in a direction of giving more power to the commercial sector and that is a change of policy, sir.

Mr. Cordiano: It is not an entire change of policy.

Mr. Johnston: I can bring you out Sheila Copps' statements ad infinitum. I have been here a long time, Mr.

Cordiano, I remember these things.

Mr. Chairman: Now, Mr. Cordiano...

Mr. Johnston: I would be happy to show them to you.

Mr. Chairman: Mr. Cordiano, I wonder, you will get your opportunity to respond.

Mr. Johnston: And the federal and provincial conservative position has been one of favouring the mix and not seeing it as such a bad thing to have the commercial sector grow especially as the demand for day care has grown because up to this point the real growth in day care has been in a formal day care and private home day care as a result of just keeping the welfare bottle and as soon as anybody gets away from the notion that the welfare bottle should disappear, then you have some real problems in terms of increasing stock. And one of the arguments that I am sure is behind the new liberal direction in all of this in Ontario...

Mr. Chairman: Is this a question of the delegation?

Mr. Johnston: Yes, it is, as you will soon see. And the rationale behind it-- it is interesting how nervous people get when they start to hear it coming back at them.

Mr. Cordiano: It is very interesting, Mr. Johnston.

Mr. Johnston: I am sure it is.

Mr. Cordiano: I would like to hear about your economic theories.

Mr. Johnston: And the rationale behind it is that if you want to create new spots-- well, one: politically it is great to give a tax credit because everybody likes the idea that the taxes are going down even when at this point it is primarily an illusionary kind of thing; the second side is that it is very expensive to create new day care spaces, capital costs are very high and our present system that we have in Ontario is a total failure and everybody has known that ever since Norton brought in his \$11-million a year thing in which a high portion was for that, day care initiatives and, therefore, if you enhance the commercial prospects in such a way that you give them direct grants, you can make it like the nursing home industry and you can maybe even interest Consumers' Gas into getting into this type of service as well as in nursing homes and they have the capacity to access money for capital construction which the non-profit sector does not have and that that is what is behind this very notion that this will be in fact the only way that government can, in their view, create new day care spaces without a huge cost to them and the commercial sector

will take care of this and, therefore, there will be an enormous expansion in commercial day care and a proportion of decline in the private day care.

What do you think of the analysis?

Ms. Rothman: Well, I think -- I will say this to you that I think there is (a) that strong possibility and I will have sent to you a newspaper clipping from a commercial operator in Alberta, whose name escapes me at the current time, but he runs a chain of kinder care and he actually quotes, if you want to go into big real estate in Alberta -- I mean, if you want to make big money go into real estate and if you want to make a little less money go into day care.

And, you know, it is clearly that \$12 a day operational grant in Alberta that has encouraged him who had nothing to do with day care before to get in there and he has amassed a lot of real estate over that province and, quite frankly, I think that is where public dollars will go, in amassing real estate, whether it is for the little guy with three centres or the big company with 40 centres and I do not think that is a good use of scarce public dollars for Ontario's families.

Mr. Chairman: Maybe you could send us a copy of that.

Ms. Rothman: I will. I will, actually.

Mr. Johnston: We have it.

Mr. Chairman: Now, that you have asked that question and you have received your response I am going to move on to...

Mr. Johnston: Absolutely.

Mr. Chairman: ...others and I am going to give equal time. The next speaker I have is Mr. Cordiano.

You are up Mr. Cordiano.

Mr. Cordiano: Well, I was really quite entertained by Mr. Johnston's dissertation this morning and, yes, I probably do have a few things to learn around here, Mr. Johnston, before I get to your breadth and scope of experience at Queen's Park.

But let me just explore, it will not take long -- no, no, no, I have a great deal of respect for Mr. Johnston -- I just want to explore a couple of issues with you.

Firstly, the fact is we do have 50 per cent of our spaces in commercial sectors.

Ms. Rothman: I think that is perhaps not clearly a fact. Well, I am sorry to interrupt...

Mr. Cordiano: What do you mean by that?

Ms. Rothman: I am sorry.

Mr. Cordiano: Okay, you can elaborate.

Ms. Rothman: I think one of the things that we really do not know -- one of the things I would like to say to this committee is I think before making -- you know, I do not think we really have sufficient evidence. I happen to have recently done some -- trying to gather some statistics on licensed spaces for a publication that I am doing from work and, in fact, the category -- the ways in which statistics are kept in this province is not very clear, it is not clear that we have 50 per cent. I just want to say that.

Mr. Cordiano: Well, we have got less than 50 per cent according to...

Ms. Rothman: It not clear what the number is and I would think before going forth on a major venture that one should have a better information base, first of all, I guess I would say.

Mr. Cordiano: Our best estimates are that it is less than 50 per cent but we use 50 per cent in this committee and I have accepted that, so I just throw that out as a generalized statement.

But on the other hand we have -- let's just say we have a significant number of spaces in the commercial sector that have existed for some time and we have seen a slowing down of growth in the commercial sector over the last number of years and an increase in the not-for-profit and public sector, a little bit greater than in the commercial sector so we have not really seen a far greater increase in the commercial sector than in the not-for-profit and public sector. I think it is a couple of percentage points different in the last few years anyway, I do not have the figures in front of me.

But what I am trying to get at here is the fact is we do have these spaces currently existing and if you speak of getting to the point where I suppose all of us would like to get to, at least the intention of this government is to get to that point which you speak of, how do we get there...

Ms. Rothman: Which point is that?

Mr. Cordiano: The point where we do have a day care

system which is more accessible and a public service rather than a welfare service and one which is for the most part not-for-profit; how do we get there from here? That is the key question, and do we allow, as you say, no -- do we allow the commercial sector to fall apart basically if we do not do anything about the quality of care that is provided right now in the commercial sector, if we do not look at that as an issue to be examined by this government and one in which we are concerned about the quality of care, in addition we are looking at the potential growth for the not-for-profit sector and we are not looking at growth in the commercial sector, despite what Mr. Johnston has said.

I mean that is the stated intention of this government. So how do we get to the point that you want to get to without sacrificing quality in the commercial sector, without seeing a real deterioration in quality in that sector.

Ms. Rothman: I will be honest with you, the \$3 a day grant that has been proposed or discussed in the media by Mr. Sweeney is not going to bring you the quality.

Mr. Cordiano: It is not going to harm the quality though.

Ms. Rothman: Pardon?

Mr. Cordiano: Anything you put into establishing a higher grade quality is better than what is there now; is it not?

Ms. Rothman: Well, but I would make the comment as I made earlier, it is extremely difficult to determine how that will have an impact on the quality in the commercial sector. There are simply not enough safeguards. And I think I would argue to you, if they do not get the grant, they are not going to deteriorate and go away, they will still be there.

I think what you have to do is concentrate and that will probably take significant involvement of school boards which I understand the Ministry of Education and certainly the Deputy is particularly interested in. I know the Association of Large School Boards of Ontario is, you know, looking very seriously at that; in other words, looking at the issue of space, physical space.

Mr. Cordiano: Because that is a big concern.

Ms. Rothman: Obviously that is a major concern. There will have to be a significant major capital funding program for communities where, in fact, you should be building a day care centre -- day care centres and having, you know, significant start-up costs for supervised private

home day care, but you have to target that.

You have to take the proactive role and you have to provide community-based staff time, regional -- the equivalent of Co-op Housing Federations. What I am basically saying is you have to make the choice to go in a different direction, target it so that in that community people can go to a range of services.

Mr. Cordiano: What happens in the meantime to the other sector when we are going in that direction; do we allow it to die on the vine?

Ms. Rothman: I do not think they will die on the vine, to be honest with you, because the need is still tremendous. People are not going to take their kids out. The difference -- you know, it is hard to know where that \$3 a day exactly will go, whether it will really reduce fees, whether it will increase salaries or whether it will go into the mortgage, I will be real honest with you.

Mr. Cordiano: But according to your views and according to many others, quality in that sector is deteriorating, is not as good as the not-for-profit sector and the public sector; what we are saying is: We have got to do something about this, we have got to do something about quality because we do have, in effect, a significant number of day care spaces which are going to be very difficult to replace in the short term, almost impossible to replace in the short term.

Ms. Rothman: And I am basically saying, I do not think that you are going to replace them, I think that what you are going to do is expand the other sector and I think what you will also do is some serious discussion with commercial operators about where they wish to go and if some of them who claim that they really do not have very much left over at the end of the year, wish to change the status of their situation.

You know, that is something that I do not have a lot of data on and I would assume that some would be considering that. Certainly if you talk to the local licensing consultants, they do have people who are saying they would change.

Mr. Pierce: Are the majority saying that?

Mr. Johnston: I am just trying to understand his question.

Are you saying it is harder to determine the quality of care in the profit sector these days and to maintain it than our present system than it is in a non-profit system? Are you saying right now that...

Mr. Cordiano: I am not saying that at all.

Mr. Johnston: ...the Conservatives are admitting that that they are not seeming to be up to scratch and they need this extra \$3...

Mr. Cordiano: No, I said that...

Mr. Johnston: As well as the non-profits.

Mr. Cordiano: Mr. Johnston, if you heard correctly I said exactly this: That there are many reports that indicate that quality in the commercial sector is not what it is in the not-for-profit sector; that is, it is a lower grade quality. That is what many groups have said to this committee and that is what many reports have said. Now, if you want to argue about that, I am not in a position to argue about those reports.

Mr. Johnston: I am not going to argue.

Mr. Chairman: I am not going to allow the argument.

Just a second. We have people here who are giving us information and we want to get the information from them. I do not think that it would be of any productivity for us to debate it between ourselves at this time.

We have found that this find in the hall is perhaps going to take us a little longer into the day and I have still three speakers. So I am not going to cut it off, we can go into the afternoon if you like. Our presenter from Ottawa is here and...

Ms. Rothman: And I have to go back to work.

Mr. Chairman: And I believe that I am getting the notification at least one of our presenters has to leave, so Mr. Cordiano do you have further questions?

Mr. Cordiano: No, that is it, Mr. Chairman.

Mr. Chairman: Dr. Henderson?

Dr. Henderson: Thank you, Mr. Chairman.

I have enjoyed the presentation. I am not philosophically opposed to the position you take, however, I am fond of asking questions I guess which fortunately is the job I am here to do right now.

I am not yet quite convinced that we are not talking about a pseudo-solution in trading in one set of problems for another, particularly on the question of -- I think what

you said or certainly implied to the effect that the profit motive encourages people to cut corners and cut back.

Now, there certainly are many ways in which people working for profit sometimes do that, but having worked in not-for-profit kinds of institutions, I can tell you that people who are working not-for-profit do a heck of a lot of that too and I am just wondering if that has been thought through? Do we really know that there is going to be more of that kind of sin, if I can call it that, that kind of abuse of the system going on if the profit motive is there than if it is not? Do either one of you want to speak to that?

Ms. Conden: Well. The SPR Report that came down recently for the Special Committee, I mean, showed that the not-for-profit sector was a much higher quality.

Ms. Rothman: Well, I would -- actually this is something you might not have heard. I would like to strengthen the non-profit sector quite frankly. I mean, I would like to strengthen the accountability, you know, and currently now to establish a corporation without share capital does not take much, you know. The Quebec Day Nurseries Act has dealt with some of these issues and it mandates that every licensed non-profit centre in order to get that Quebec direct grant, if I am correct - I think I am correct - must have at least 50 per cent of parent consumers on the Board of Directors, there has to be another level of accountability, so it is not, you know, the supervisor, her brother and her husband on the Board of Directors. I mean I do have to say that we have to strengthen that non-profit sector as well.

So if you are asking, how are we going to ensure quality, that is a broader, more difficult question and we do have to strive for that in both the non-profit sector as well as the commercial sector.

Dr. Henderson: I guess I am raising the question of whether there could be and illusion tucked into this and that is the illusion that not-for-profit reduces or eliminates cutting corners whereas for-profit preserves and accentuates them, and I am not able to say one way or the other, I am just interested in your views about it.

Ms. Rothman: Well, the view is when you are under resourced and you are tight sometimes, you know, you do not do as you would wish to do, but there is not an incentive to have \$10-thousand left over at the end of the year.

I actually went to the budgets of the 100 non-profit day care centres in the City of Toronto that get the grant and I actually have been talking to some foundation and accounting people and in the non-profit centre it is

considered in the acceptable -- and I should say in a non-profit organization, service organization which are often human service organizations - it is considered within the realm of -- what is the word? -- acceptable practice to have a surplus of up to roughly one month's expenditures, so what is that? 8 per cent, 6, 7 per cent.

Of the hundred centres that we saw in '86/87, you could count on your hand anybody that had that much left over, instead you sometimes see one or two per cent, you see some operating deficits and that is in a very under resourced non-profit system.

So I guess what I am saying is probably there is corner cutting but there sure is not an incentive to do that. You do not have that other - what is the word? - interest in your operation of having something left over at the end.

Dr. Henderson: I certainly agree with the point you made that the kind of large scale capitalism in day care that you described is occurring in Alberta is undesirable.

I just want to ask one other question. When you say that in human services, in the human services area there is no place for the profit motive, I think you said something along those lines, it occurred to me that where you would draw the line because almost all services are human services and I suppose there is a continuum in the way we think about them and at what point would you say: Well, this kind of human service there can be a profit motive and this kind of human service there can't?

Day care, clearly you feel that there ought not to be a profit motive; health care that point is widely made, in the area of pharmaceuticals it is becoming a kind of a gray area. What is the cut-off point wherein one says that the profit motive has no place in the delivery of this or that kind of service?

Maybe that is an open question. I do not know if...

Mr. Chairman: It is a little broader, Doctor, than our mandate I think, but if the witnesses want to...

Ms. Rothman: I do not have a comment.

Mr. Chairman: Are you finished Dr. Henderson?

Dr. Henderson: Thank you, Mr. Chairman.

Mr. Chairman: Mr. McKessock?

Mr. McKessock: I guess just to follow up a bit on what Jim was saying there, I found that in the private

sector that you had to produce quality or you failed and often in the government you see they can go on inefficiently give poor service for a continued length of time.

I guess my question would be: If there were two facilities, equal facilities side by side, one profit and one non-profit, the one for-profit had appeared to have -- well, had a good reputation from the parents who put their kids in and their staff who is apparently because their staff was better and because a lot depends on the personnel, right. Which would you put your children into?

Ms. Rothman: Is that a personal question?

Mr. McKessock: That is a personal question.

Ms. Rothman: Well, I would most likely put my child in a non-profit centre. I am probably not the average person. I would also want to look at staff qualifications, how many people...

Mr. McKessock: No, but that is what I said because the staff was better and they had a better reputation in the one for-profit than the non-profit.

Ms. Rothman: I would ask them to see their budget because I would not believe it from what I know about the details. I am honest, but I am not the average person.

Mr. McKessock: I am not talking about budgets, I am talking about the quality of care. Like, the parents coming out that had their children in this one for-profit are saying: I want to put my kids there because the programs are better, the staff are better, the personnel is better. Would you still put yours in the non-profit if that was the case?

Ms. Rothman: I think what I would have to say to you is I would probably be a fairly tough consumer and I would really want to see some evidence. I am not sure what you mean by better?

Mr. McKessock: I am talking quality.

Ms. Rothman: I would ask an intense staff, how many are trained, what is the level of training, what are the working conditions like and then tell me about your French and your computer and whether really you really do that or you do not, and I would sit there for a half a day or a full day in each of the centres and see what it is like and, in fact, I think we need to be saying to parents to do more of that everywhere.

Mr. McKessock: I agree and that is what I was saying, that the parents coming out of this facility were saying

that they liked it and they liked the programs and the staff was good.

I have also found that in private companies it seems to be easier to get qualified staff and, more importantly, to get rid of poor staff easier than it is for government.

Ms. Rothman: Can I ask you first of all where are you from and how you happen -- that is quite unusual. I would be interested in knowing more about that.

Mr. McKessock: For it to be harder to get rid of poor staff in private sector than it is in government?

Ms. Rothman: Yes, and you also made the statement that it was easier to attract quality staff. I would be interested in knowing a lot more about that. What area are you from?

Mr. McKessock: Grey County, a hundred miles north of here.

(Interjection)

Mr. McKessock: Well, quite often these days dollars attract the staff.

Ms. Rothman: And working conditions and professionalism.

Mr. McKessock: That is right, but would you agree though that no matter what facility you are in, that the staff makes the difference of how your kids are going to be treated?

Ms. Rothman: Certainly I would agree that is probably the most critical factor, but I think we would have to talk more about what we mean by does staff make a difference.

Mr. McKessock: I think we agree on the fact that the staff is the important thing. I guess my observation, as I mentioned, was that government or private sectors can very easily get rid of staff, but it seems difficult sometimes for the public sector organizations to.

Ms. Rothman: But, remember we are not talking about all directly operated municipal centres, we are talking about a network of community-based non-profit centres which are not exactly the same as the centres operated directly by municipalities.

Mr. McKessock: That is true, not direct government control.

Ms. Rothman: We are talking about a mix.

Mr. Chairman: Okay.

Mr. Leluk?

Mr. Leluk: Thank you, Mr. Chairman.

I just want to follow on Dr. Henderson's statements and Mr. McKessock's statements. I am having some difficulty trying to understand. I came a little late in your presentation.

If I understand what I heard, you have indicated that the quality of service in the for-profit day care centres is not what it is in the non-profit day care centres and that there is no room for commercial enterprises in the day care field; is that correct? Did I understand that correctly?

Ms. Rothman: I did make those first two comments and with regard to the last comment, what I really said was it is my personal opinion that I do not think that scarce public dollars should be directed to the commercial sector in child care and I think that we are in a key decision point in making those choices and that is why it is important to consider it. They can exist, I just do not think that public dollars should support them.

Mr. Leluk: But as far as you are concerned, there is room for a commercially operated day care facility as long as someone wants to...

Ms. Rothman: Pay for it.

Mr. Leluk: ...pay for it.

Ms. Rothman: Sure, in the same way that there are private schools.

Mr. Leluk: But you are opposed to public funding through taxes going to subsidize these centres, you think that the money should only be provided for the non-profit type of operation?

Ms. Rothman: I did not say through tax -- well, what I am really saying is I object to direct operational funding to the commercial sector, yes.

Mr. Leluk: We are talking about tax dollars.

Ms. Rothman: Yes.

Mr. Leluk: Because that is where the money is going to come from.

Ms. Rothman: Okay, that is right.

Mr. Leluk: Now, I have some difficulty. I mean, you say there is room for commercially operated day care facilities but you feel that these facilities do not provide the quality of day care that non-profit centres do. You do not feel there should be any profit.

I am one of those free enterprisers, that believe that profit is not a dirty word. I think if there is a need, which we know there is, for this type of a service and there are people who happen to want to get involved in this, in the provision of these social services and invest their own dollars, then they should be entitled to make some profit. Now, profit is not a dirty word. We have had commercially operated day care facility people here.

(Interjection)

Mr. Leluk: And I just want to say that there was a family here, a husband and wife and a daughter who operate two day care facilities in Mississauga and if I recall correctly, and I stand to be corrected, I think they indicated that in 30 years of service their total profits were in the vicinity of \$48-thousand over 30 years.

Now that is -- we are talking about what, less than \$2,000 a year, so I find it difficult to believe that because a commercial enterprise is involved in providing this type of service, that people are strictly in it for profit, that we are looking at dollars and cents, you know, I just gave an example. We are looking at a family involved for 30 years in providing a very much needed social service who only made \$48,000.

Mr. Chairman: I think I can correct that, as my recollection of that, and I may be wrong, was that that was the profit after salaries had been paid.

Mr. Leluk: Well, the profit...

Mr. Chairman: Obviously, salaries had been paid to those individuals.

Mr. Leluk: Yes. But the other thing is that I find it very difficult to believe that there are not non-profit centres that may not have good quality care. I think the quality depends on the personnel, I do not necessarily -- I find it hard to believe that there would not be some non-profit day care operations that do not have poor quality care.

Ms. Rothman: I think you missed that as well. I said as a sector, and there have been some studies, cross national studies -- I am presuming your committee has heard of that, if they have not they will be hearing -- that did

some ratings of day care and said that as a whole, and they looked at a thousand day care centres, the licensing people, as a sector one out of four -- no, as a sector non-profit day care on 26 measures of everything from child development to relations to the community, safety and nutrition, were rated as high or were, as a sector, that is a large group, commercial sectors were rated as lower quality.

So that obviously there are going to be some individual variances in that. You know, I am actually going to ask the committee, one of the other people in the audience...

Mr. Leluk: Do you feel the reason for that is strictly the profit motive that these commercial operations tend to...

Ms. Rothman: Yes, I think that is the major motive. As I talked about, your major cost is salaries and we are all agreeing that qualified personnel...

Mr. Leluk: Well, how do you explain this family then who has operated this business in Mississauga who has made a profit of \$48,000?

Ms. Rothman: Well, I mean, what I would also say to them is obviously if they are not yielding significant -- if they are among the group that is not expanding rapidly and into it for the big money, I would ask them then, versus their individual choice, in a broad public system and providing service for families across Ontario, then I would think that they could operate very similarly as a non-profit centre with a similar salary and that \$2,000 year that is left over goes back into the coffers. I mean, I do not think that that is so very different.

Mr. Leluk: So if I understand you correctly from your last statement, you are inferring then that any commercial operation involved in the provision of day care service is strictly in it for the profit motive, for the big money?

Ms. Rothman: No, I am not saying that. I am not-- listen, I do not think it is my business to get into why that particular family is doing that. What I am saying is the government of Ontario...

Mr. Leluk: Well, I am talking generally now. We are not talking about that specific example that I gave.

Ms. Rothman: I am not talking generally either. I am simply saying, if what the committee is charged with looking is the role of the commercial sector in an expanded system, I do not think that precious public dollars are best used in enhancing and broadening that commercial sector.

I want to say one thing to the Chairman.

Mr. Chairman: I think that is a fair statement, Mr. Leluk.

Mr. Leluk: Yes.

Mr. Chairman: I mean, that is really what she was saying and I think it has been well said.

Ms. Rothman: I just want to add that there is one other deputant from the community who might wish to take my place for a short time, if that would be possible.

Mr. Chairman: Is that the Coalition?

Ms. Rothman: No.

Mr. Chairman: The difficulty we have is that we drew your group in from the hallway and...

Ms. Rothman: Five minutes.

Mr. Chairman: The problem is we have a lady who has come all the way here from Ottawa and she was the next deputation and we have had an hour of this and it has been extremely interesting, unless you have something to add to -- maybe you could whisper in somebody's ear what it is.

From the Floor: Could you just give me two minutes?

Mr. Chairman: You will have to come forward then if you are going to do that and perhaps identify yourself. We will give you two minutes.

Ms. Beach: Thank you. I will speak as fast as I can.

Mr. Chairman: We will keep you to your word.

Ms. Beach: My name is Jane Beach and I am one of the day care co-ordinators for the City of Toronto and hopefully, having listened to this I think that people are very confused about -- this member was talking about illusions and I would just like to shed a little light.

I think I have seen more day care budgets than most people. I would just like to refer to the 1981 service plan of day care that was done by the province. I was hired as a consultant to work on that and one of my tasks was to review every day care budget in Metropolitan Toronto.

I should add that this was the first time I became quite concerned about profit making day care. As you probably know, in Metropolitan Toronto commercial operators can add a ten per cent profit into their budget as a line

, item which is paid for under the subsidy dollars, but that is a very small amount of profit. The biggest way that commercial operators are making profit is through real estate, that their total mortgage payments are able to be funded through public dollars.

Now, we are saying that we cannot afford to buy out all these commercial operations and develop a non-profit system because it would be too expensive, so what you are suggesting is you would have to pay them twice; you already bought them day care centres right across the province and up to \$52,000 a year in mortgage payments are being claimed -- this was in 1981 so you can imagine how costs have escalated since then.

The second argument is that the commercial sector is more cost efficient and more effective and balances the budget. Well, another study I worked on for the 1984 Katie Cooke Task Force Report doing a study of work place day care across the country, that there was not one private sector company who is involved in day care who has chosen commercial day care as an option for their employees and I think that that just says that if those successful corporations felt that commercial day care was better in quality or more cost efficient or effective, that they may have taken that approach.

I would also hope that you would look at the City of Toronto as an example of a local municipality who has taken concrete steps to develop a non-profit system through direct grants to non-profit day care centres only. I am sure you will hear that in much more detail from the Mayor when he comes, but it has really stimulated the development of non-profit day care, it has had a major impact on salaries which have gone up by about 22 two per cent and fees have only gone up by five per cent and there is real planning taking place.

I would suggest that if you looked a little more closely at that you can see that it is possible to do that and I know I spent more than I was permitted.

Mr. Chairman: That was pretty good actually. You have several seconds left over.

Mr. McKessock...

Mr. McKessock: One clarification.

Mr. Chairman: ...unless it is a question arising out of that specific item and the same with Mr. Cordiano...

Mr. McKessock: It is arising out of that. Just one clarification. Unless the Federal Department of Revenue treats day care business differently than it does other

businesses in the Dominion, you will not be allowed to take mortgage payments off as expenses.

Mr. Chairman: Well...

Ms. Beach: I did not say less expensive, but it is a line item in a budget and if you seen the Metro budget which helps pay for low income parents, you have to do a line by line budget that you present to Metro, you calculate then what it costs you to provide care to that child per day and rent or mortgage payments are...

Mr. McKessock: They are only interest payments though, right?

Ms. Beach: No, no. Listen, I have seen all the budgets. You can say I pay \$52,000 a year in mortgage payments, therefore, the bottom lane says it costs \$20 per day to provide care for that child.

If you like, I would be happy to bring a Metro day care budget and walk you through it line by line.

Mr. Chairman: What I was going to ask you, you have indicated at least one report, the Katie Cooke Report you were involved in.

Ms. Beach: That was the Liberal Government's Federal Task Force.

Mr. Chairman: You submitted something to the Katie Cooke Report, I wonder if you could provide that to...

Ms. Beach: Well, it was a paper that was commissioned.

Mr. Chairman: We have that. Okay, we have that already.

Mr. Johnston: Were you involved in the service plan?

Ms. Beach: The service plan, yes. Actually, it was shelved by the government when it was presented in 1981, the service plan for Toronto and Ottawa/Carleton.

Mr. Johnston: Can we see if we can get that through the Ministry of Financial Services, Joe?

Mr. Chairman: Mr. Cordiano has indicated that he will attempt to do that.

Mr. Johnston: I have always wanted to do that.

Mr. Chairman: I want to thank you very much and I am sorry, having brought you from the hallway -- it has been a

stimulating, provocative and certainly very rewarding having brought you from the hallway, and I am sorry we have to send you back to the hallway but we do have a scheduled...

Ms. Beach: Well, if you ever have gaps again where nobody shows up, I would be very happy to come and talk about financing of day care and budgets and how you are able to hide all kind of profit items. You also -- on my way out...

Mr. Chairman: I will tell you what we will do. The Clerk is here, perhaps she can speak to you right now because I am sure there are some gaps where we would be more than happy to hear from you on another occasion.

Mr. McKessock: I would like to see that.

Mr. Chairman: And perhaps the sun will shine on that occasion.

Thank you very much. We appreciate you coming forward and assisting us on that.

The next deputation is here and the Clerk is handing out a written copy of the brief.

Is it Mrs. Somers?

Mr. Mitchell: Mr. Chairman, may I just ask Rosemary. Rosemary, what is your schedule for going back to Ottawa this afternoon?

Mrs. Somers: Well, I am supposed to be on a two o'clock plane, but I can try to get on at four o'clock.

Mr. Chairman: Let us start now. I know what Mr. Mitchell is suggesting, he slipped me a note, but perhaps we should put it off till the two o'clock, but let's hear from Mrs. Somers and if we get into a difficulty I am sure that there are enough flights between here and Ottawa.

Mrs. Somers: I am sorry I was late too.

Mr. Chairman: We can re-arrange it, but we got off to a slow start this morning, let's try and get on...

Mr. Mitchell: Well, Mr. Chairman, just as long as I can be assured that we will give Mrs. Somers the same amount of time that has been given the other groups. I do not expect, if we start now, it is lunch hour to see people leaving and giving Mrs...

Mr. Leluk: I have an appointment.

Mr. Mitchell: That is my purpose.

Mr. Johnston: I am sure there will be enough of us here to give her our rapt attention for as long as she can last.

Mr. Mitchell: I would hope so.

Mr. Chairman: All right. Would you like to identify yourself for Hansard, Mrs. Somers, and then proceed with a copy of your written brief which we have before us.

Mrs. Somers: Thank you. My name is Rosemary Somers. I am a member of the Ottawa-Carleton Day Care Association, I was the past President and I was asked to come today to present the brief.

My actual paid employment, that is my voluntary activity, is the Executive Director of the Andrew Fleck Child Centre which is one of the older voluntary non-profit day care centres in Ottawa.

The Ottawa-Carleton Day Care Association has been around since '74 and consists at this point of 32 day care operators. All of them at this point are in the not-for-profit sector. We put this brief together because we felt at this time that this issue was obviously going to surface and become very important and, in fact, of course, the events of yesterday have shown that we were on, bang on.

Since its inception, the Day Care Association in Ottawa has lobbied all levels of government around the quality of day care and this is just, you know, one more of our efforts. I think what I want to emphasize to you is that we are quite convinced that public funds must be directed in the area in which they will create the greatest benefit and we, from our experience and our reading in Ottawa, have no doubt that that means that the funds have to go into the not-for-profit sector.

I would like to sort of use an analogy and I do not know whether this has been said. We really are at a watershed at this point and if we look back to when we started the school system and if we put the money -- when we made a decision to fund a public school system, I think if we had not made that decision but had allowed it to go on a for-profit system, one wonders what sort of a system we would have today and I think when our friends here talk about the small operator who runs a good day care centre, we are not really quarrelling with that, it is not really that I run a good day care centre and you, the profit operator, runs a good day care centre. I can accept that, but what I am really saying to you is what kind of a day care system are you going to put into place in 10, 12, 15, 20 years' time? I think that is the decision that you are really going to make and my belief and the belief of my association

is that if we go the way we go, it seems that we are going to go from yesterday's announcement, we will see some really very disastrous things happening.

I do not want to read the report to you. I hope you will read it yourselves, it is not very long, but I would like to emphasize what we have written about auspices, about the fact that we feel that public money must go in to create and improve services.

Experience has shown, and I do not know whether we can convince you any more, but all the research shows that the non-profit sector, whether it is here or whether it is in the States, does on the whole a better job than the for-profit sector, and it is our experience that municipalities which are accountable to the electorate and community boards, voluntary boards and parent co-ops are doing a good job of providing care and they are accountable.

In that sense they are also in receipt of a great deal of volunteer time. I have not been here, I do not know what other points have been made, but in a board like mine we get hours and hours of volunteer time on financial matters, on labour relations matters, on the whole issue of program planning which, if it was not there, either the quality of the centre would be a lot lower or, in fact, we would have to hire other people to do the job for us.

I was very disturbed to read in the press the quotation from Mr. Jeffery who was the President of the Association of Day Care Operators here in Ontario appearing before you when he said it is not the public's right to know how a day care centre is operated. Why ever not? I mean, I think if you put money in, it is not only your right, it is your duty to find out how that centre is operated and I was really quite amazed that anybody would make that remark to a committee of this sort.

I think we have to provide you with audited statements and make those public and we have to nail them to our gate posts or wherever you think we should put them.

I just feel that day care is not subject to the market, it is not -- it is not like producing diapers or baby cream or motor cars, it is really quite different and there are not really any so-called efficiencies that one can do, I feel, that really make a lot of difference except by cutting salaries and I think those of us who have made a commitment to improve salaries are just not prepared to go that route.

We know that in Ottawa that the salaries in the for-profit sector are 20, 30 per cent lower than we pay and these people have very little in the way of benefits. They are lucky if they get their OHIP paid.

I would like to just talk about licensing and regulation. I am frequently asked by people who are not familiar: why do you worry so much, because if you have proper licensing and the thing is regulated, then surely it will be good. Well, honestly I do not think that is true. I do not think that licensing or regulation produces anything but minimum standards. That is all you can maintain. You have to be self-regulating in order to produce high standards.

And licensing in Ontario amounts, in my centre, to one visit a year from the provincial consultant. She is very helpful and she always makes a few suggestions and we always fall short in some small area, but it really does not really do very much to keep me on my toes in that sense. We have a couple of visits from the health inspector, perhaps one from the Fire Marshal and that is the extent of our regulation and licensing.

We have in Ottawa an example of one day care centre that was consistently not maintained in the regulations and for many years they had a provisional licence rather than a proper licence and each year there was something they were required to do and they did a bit of this and they did a bit of that. The day care consultants, in other words, the representatives of the Government of Ontario never closed that centre down. It came in the end for the municipality to withdraw the purchase of service agreement from that centre.

Mr. Chairman: Sorry, is this a for-profit or not-for-profit?

Mrs. Somers: A small for-profit centre, yes.

Mr. Chairman: Sorry?

Mrs. Somers: The young man who ran it went into antiques afterwards and did a good job. I mean, that was really where he probably should have been from the beginning.

The other example was a centre that got money from the municipality to put its wages up in accordance with their agreement with the Union. That money was never passed on to the staff. There was a big and ugly strike and the end of it was that the operators purchase of service agreement was withdrawn by the municipality. In other words, the municipality has done the regulating, unfortunately it is not really the standards.

Just to have another little discussion about the for-profit operators. I think that many people have referred to Dr. Michael Kulczynski's study for the Special

Committee on -- this is the one where all the day care consultants throughout the country were asked to rate the centres and as you have probably been told, the municipal centres came up with the very best, with the non-profit sector next and then the chains, the day care chains and then lastly the small for-profit operators. There were some differences, there were some good for-profit, there were some poor non-profit, but on the whole that was the picture and that has been consistent with all the other studies that we know of.

The only thing I would like to tell you about the for-profit operators and that is that they have consistently lobbied governments to lower standards. I have pointed out that the Ottawa Day Care Association has done a lot to lobby for good standards, we have been in here and in our own municipality and this is the experience here in Toronto, it has been the experience in Alberta, and it is certainly the experience in the States, the day care operators lobbied to the President for lower standards.

We had in our municipality an effort for one of the big chains to come in and start day care centres, one or two, and the provincial consultant said that they would not license them with the space requirements, you know, because the space that they wanted to allow per child was not within the regulations and they said that if they could not build the centres of that small size and have the large number of children, that they could not make a go of it. So so far we have managed - with help from our provincial consultants - to fight off that particular step but I do not think it is over yet.

The last point I would like to make is the issue of pay equity. I presume that this government is committed to pay equity. I am not sure -- maybe if someone could -- I do not know whether it is in the legislation, but...

Mr. Mitchell: It is in the Justice division as a matter of fact right now, the pay equity.

Mrs. Somers: Is it? Okay. Well, let's hope you are then.

I feel that if we push this new move through the governments that we are going to create another dreadful ghetto of women who are very low paid. I just feel that we will see a growth of commercial day care, so small day care centres are very hard to unionize so that particular way of fighting for salaries is very difficult in a lot of small operators, it is rather like the catering industry which is very similar and manages to avoid, and I think, you know, you should think about that. I mean, it is not particularly an equality issue but it is certainly an issue. Do you really want to push women's pay further into the dark ages?

I would like to make just one last comment. In spite of all the things I have said, Ontario day care is the best day care in Canada. It is certainly probably the best, well, some of the best day care on the North American continent and I hope that we will be able to continue to push ahead and improve our day care with your help.

Mr. Chairman: Mr. Mitchell first and then Mr. Cordiano.

Mr. Mitchell: Thank you.

First, Rosemary, before we get into the questions, if we should keep you here until at least one o'clock because of the weather you might have some degree of difficulty making the two o'clock flight and I was wondering if you want the Clerk to get you a bit of leeway by trying to get you on to a later flight or not?

Mrs. Somers: It is okay, I will stay and I can...

Mr. Mitchell: You will play the game.

Mrs. Somers: I will do the best I can. Thank you very much for the offer.

Mr. Mitchell: Apart from the one particular centre which you mentioned which we are knowledgeable about in the Ottawa-Carleton district, can you tell me how you feel those centres that can be identified as for-profit operate in Ottawa?

Mrs. Somers: It is very difficult, I mean, but most of them I would not want to send my children to.

Mr. Mitchell: What about the Children's Place, Rosemary?

Mrs. Somers: Am I on -- what sort of ground am I on?

Mr. Johnston: You have no protection. You should have been warned of this by the Chair. In terms of...

Mrs. Somers: I think that is fair. I mean, these are people I work with and know and...

Mr. Johnston: She should have been given a warning.

Mr. Mitchell: No, I think that is fair. I will not use names.

Would you not, however, agree that there are not in Ottawa-Carleton some very good, I guess, for-profit operations?

Mrs. Somers: No, I would not agree that there are some very good ones and I think on the whole that staff is still poorly paid and they are not as well equipped as they should be.

Mr. Mitchell: Okay, I am not going to argue salaries because I quite accept the points that have been made up to this point in time that salaries are generally low. I accept that.

But I guess and maybe I am a little further away from the forest then because I have visited a number of them, as you know, and have met with a number of them and I find them -- some of them are, to me at least, if my children were young enough I would be quite prepared to put my children into them because I feel quite confident that they are operating well. But let's get to the whole issue then -- I am sorry, go ahead, Rosemary.

Mrs. Somers: I was just going to say, would you not feel happier if these operators would create some kind of a board or parent advisory committee somewhere where people in the community would have some input?

Mr. Mitchell: That is not as important to me as if the child is receiving proper care, you know.

Let me get on to -- you in fact implied, and a lot of people have implied in the briefs they have made that the care given in the for-profit centres is not as good as is in the non-profit centres.

You also, in your discussion, made the point that the one centre in question that you referred to was not in fact closed as a result of Ministry investigation but because of the municipality becoming involved.

What I suggest to you, because day care is a provincially controlled situation to the greatest degree, could not the same situation happen in a not-for-profit centre in that the inspection people and so on are not looking at the thing as well as they should?

Mrs. Somers: Yes and, I mean, there are some centres, but presumably there is a board of management or parent board which will also be monitoring that situation on behalf of the community and I feel that when that point -- not only does the day care consultant go back to the operator and say: Look, you know, you are not coming up to scratch in this particular area, but she goes to the board of the set centre and the parents and says: I am concerned about this area of your centre. You know, we would like to see these improvements made, and I think that that is a check and balance which does not exist in the other centres.

Mr. Mitchell: We just, in one of the committees that the Legislature have been dealing with, the Nursing Homes Act, and nursing homes are going to be required to have a -- I do not know the correct word -- I guess a committee representing the residents to speak on their behalf and to make decisions and so on on their behalf.

Notwithstanding or bearing that in mind rather, could the same situation not be created in the for-profit area where in fact one of the conditions to be laid down by the province might be that they would be required to have a parents committee, if you will, who would advise the centre on their shortcomings and so on?

Mrs. Somers: I would much rather see them incorporated and become a board and I think that is...

Mr. Mitchell: But, would it work?

Mrs. Somers: I do not know. I do not know and I do not know whether it will work in the nursing homes. I suspect that -- how much clout is it going to have?

Mr. Mitchell: Well, you see what worries me is that what everybody is saying here is in fact reflecting on the government inspectors and almost implying that they do not have the capability to look into the for-profit operations, at least that is what I am getting out of all of this, but I find that a very strange sort of feeling.

Mr. Chairman: No, I think in fairness, if I read what was said, it said that if you set up standards, the minimum will be met.

Mr. Mitchell: I am talking about generally, not just Rosemary's brief, okay? I am going through what I have heard since we began sitting, Mr. Chairman, that I am getting a feeling that what is being implied is that our government people from the Ministry of Community and Social Services are not able to monitor and have the necessary changes, if there are changes necessary, brought into being; that the not-for-profit centres are in fact "the best operated ones".

That is what I am hearing people are saying, it is a proven fact that the not-for-profit ones operate better because of and most of them -- and from what I hear, the reason for that is -- and this might be a point -- is that the salaries are lower so that the people within the for-profit centres do not have the incentive to do a proper job.

And I may accept that, okay, I am not arguing that. If the government were to make sure that the salaries met those in the not-for-profit sector and were in fact to lay

down, follow the same guidelines and rules that they have all the way through, are you really -- do you firmly believe that the for-profit centres could not be as good? I have some degree of difficulty based on my knowledge of some of the centres in Ottawa-Carleton.

Mrs. Somers: Maybe you should perhaps visit them all. Maybe we should have a little chat afterwards.

Mr. Mitchell: I would appreciate that.

Mrs. Somers: No, I do not really because I think that in order to do what you are suggesting you would have to have armies of inspectors and that would not be acceptable to most governments. I mean they do not want to increase the civil service, as you know, so if you are going to increase the number of day care consultants by double or treble or something, yes, maybe you would be able to do something about the standards.

But why do that? Why not give the money to day care centres to get on and do the job and allow them to self-monitor because of their boards, because of their parent involvement? I think it is a much more effective way and it is rather like your children, you cannot spend the rest of your life making decisions for them, eventually you have got to teach them to make their own and they will monitor their own behaviour.

Mr. Mitchell: All right. Not to prolong it. You are with the Andrew Fleck Centre and it is a well-known centre and a very good one, I acknowledge that.

How often would you have them in, the provincial inspectors, say, visit you?

Mrs. Somers: Well, about -- I actually have ones for my day care centre and then I run a private home day care.

Mr. Mitchell: Yes, I realize that.

Mrs. Somers: So they also come in on another occasion to do that.

Mr. Mitchell: Yes.

Mrs. Somers: They come on occasions when we invite them, if we have a problem. They have been in recently because I had a problem around perhaps changing the use of the rooms and so on, so they have been in again.

That is unusual. So probably twice a year, once for my...

Mr. Mitchell: Twice a year.

And how many current inspectors are there in Ottawa-Carleton?

Mrs. Somers: There are four of them.

Mr. Mitchell: And how many day care centres?

Mrs. Somers: Well, there is about 65 I think or 69 with purchase of service arrangements with the Regional Municipality of Ottawa-Carleton. I am not familiar on these things. But then you must remember they also go up the valley to Pembroke and Renfrew and they go out as far as Cornwall.

Mr. Mitchell: I realize that.

Mrs. Somers: And they cover not only day care centres, but they cover nursery schools as well and private home day care.

Mr. Mitchell: Even let's take, say, that figure of 65 that is 130 days if they were all to be visited twice in the course of a year, divide it by four and I am being very black and white about it all, I quite acknowledge, which is about what 30 centres apiece, 30 odd centres apiece.

I do not find that very hard work, I would not think it would be very hard work to visit 30 centres at least twice a year, if that is my responsibility and I still come back then to the argument that if the inspectors are doing the job that is required of them they could be doing the same degree of monitoring of the for-profit centres as for the not-for-profit centres.

I know there is going to be bad, but I similarly think there is going to be bad in both type of operations and I have to tell you that I still have some feeling that there is room for both, primarily based on how we have dealt with the Nursing Home Act.

Now, I would like to sit down with you and, Rosemary, I think you are aware that I have told people that anytime to please do so and I would. In fact, if you change your flight maybe we could even grab a bite of lunch together because I am concerned. Obviously each member here is concerned about their own ridings.

We have not, I think you would have to acknowledge, not had the apparent problems or the visual problems, maybe they have been underlined, but we have not had the problems that have appeared in press and so on with the exception of the one in Ottawa-Carleton and I am not sure what that says really.

Mrs. Somers: Yes. We have really a relatively strong non-profit sector and a large municipal sector and I think it is a very good day care.

Mr. Mitchell: Yes. We do have. In any event I think I have monopolized the conversation. But if you do find you are going to change your flight, maybe we could do just that.

Mr. Chairman: Mr. Cordiano?

Mr. Cordiano: Thank you, Mr. Chairman.

I just have one issue to explore with you and probably we will touch on the same lines as I discussed with the previous group that was here.

Do you think that with the resources that we now have available, and some people would say those resources are unlimited - I would disagree with that point of view. I would think that we have resources that are limited and there is only so far we can go with those resources.

If we are going to expend our resources on -- I think there are a number of choices we have to make. We have to decide whether we want improved accessibility which all of us desire, more affordable day care and certainly better quality day care. It is a question of how we accomplish that and how we are able to distribute our scarce resources among those issues and how far we go?

Now, if we decide as government policy or public policy that there is no place for commercially operated day care in this province and that no funds -- no public moneys will flow to those commercially operated centres, then we somehow have to make up those spaces that we lose or we could potentially lose, or those spaces could become potentially less desirable because of a lowering of quality.

If in fact we are allocating all of our resources in the non-profit sector and public sector and consequently over time, in the short period of time, we are looking at a situation where in those spaces we could potentially lose some of those spaces and some others would become, as I say, less desirable. Would you agree with me, that that could potentially happen in the short term, say in the next five years if huge amounts of money were not put into place for more accessibility and better quality and more affordability? Which I do not know if the resources exist. I start with that premise.

Mrs. Somers: Okay. I mean, there is a lot of money going to go into the system but, unfortunately, as far as I can see it is going to go into the wrong place and this is the announcement yesterday.

Mr. Cordiano: What do you mean by a lot of money because, you know, that is a lose term. Let's be a little more specific.

Mrs. Somers: Well, I think enough to get going if it was going, but you see, I think it is going in the wrong direction. It is not going into programs, it is going to go into parents and I think any parent would tell you that \$900 is not going to make a great deal of difference when their day care is costing five thousand.

Mr. Cordiano: Right.

Mrs. Somers: So it is going to cost us a lot of money but we are not going to get much of a return on it.

Mr. Cordiano: It is not a lot of money in relation to the amount of cost.

Mrs. Somers: I think what we hope is that the money would be put into the system in the right place and it would be....

Mr. Cordiano: Most effective.

Mrs. Somers: ...increased over the years, that there would be a commitment to put so much in this year and so much more in next year. Nobody said, you know, we have to put the whole lot in this year. That would be unrealistic.

Mr. Cordiano: Sure, sure.

Mrs. Somers: But some commitment to improving.

Going back to the whole issue of the profit operators and what one does with them, I think I would like to quote the Canadian Day Care Advocacy Association whose position is basically that they would be given three years to come into line; in other words, to set up and incorporate and if they want to go that route they would be allowed to. Nobody is going to say, you know, tomorrow you do not get another subsidy from anybody.

Mr. Cordiano: What we are talking about is basically the amount of time that is required. You see a longer term than a three year period, a longer range and you are agreeing with the three year period?

Do you think that is a reasonable amount of time?

Mrs. Somers: I feel that is a reasonable amount of time for people to get incorporated and come into line. I mean if you make that the policy and the operators know that. That is my position, that was the position in

Saskatchewan when they went over to a non-profit system and it seemed to work.

Mr. Cordiano: Their system, I am not familiar with it, but what we do have in effect are potentially 42,000 spaces that we are talking about that are commercially run spaces. That is very large. To try to convert those to non-profit, well it would be great if somebody is going to do it, but there are certainly additional resources that would have to go into that and that is the whole question that we are talking about here and how quickly you do it is really a function of the number of resources that will be put into place really to displace those commercial spaces.

Mrs. Somers: Well, some of them may in fact come on stream as part by changing their auspices and otherwise then, you know, yes, it is going to take a lot of work; it is going to require school boards and the sort of efforts that the City of Toronto has put in to persuade developers and people to put space aside for day care, to put land aside for day care.

It is very, very difficult to build a new day care centre. Back in 1970, the government of that time put in Public Works money and we built about 14 day care centres in Ottawa and that is, you know, that is really our real stock of modern day care. The rest of us are in old buildings and church basements and you name it.

Mr. Cordiano: And there is quite a number of those?

Mrs. Somers: Yes.

Mr. Cordiano: A very, very large number.

Mrs. Somers: And some classrooms, some of which are good and some of which are not, but there is nothing in the new legislation to create any spaces. I mean, we are not going to get any capital cost to start new day care centres.

Mr. Cordiano: Now, you are talking about the report that was tabled?

Mrs. Somers: Yes.

Mr. Cordiano: That is really a report, it remains to be seen what will be developed as policy as a result.

Mrs. Somers: That is the thinking, yes.

(Interjection)

Mr. Cordiano: Certainly. Well, I think we have a difference of opinion with respect to a transitional phase and how long that will take and with respect to how many

resources would have to go into that.

If we are doing it in a shorter period of time, then obviously there would be greater resources required in each of those three years. I do not think that is feasible. I do not think that we can accomplish that in three years, but that is my opinion.

Mrs. Somers: I do not understand why you feel greater resources would be required in the sense because you feel all these for-profit operators will be so disgusted by the fact that they have to have a volunteer board that they will all pack up and go into antiques or something.

Mr. Cordiano: No, no. As I understood the proposal would be after a three year period you would be required to become a non-profit centre.

Mrs. Somers: Yes.

Mr. Cordiano: I really honestly do not think that the majority of those operators would want to become non-profit, perhaps a significant portion, but from what they have said to us...

Mr. Johnston: Why?

Mr. Cordiano: ...at least to me individually.. Why?

(Interjection)

Mr. Chairman: That is a rhetorical question.

Mr. Cordiano: I do not mind rhetorical questions.

Mr. Johnston: I was wondering if you were saying that their main motivation was profit and that is why they would not switch.

Mr. Cordiano: My good friend, Mr. Johnston, thinks that that profit motive would not be there, therefore, there would be no incentive.

Mr. Johnston: That is what you are saying.

Mr. Cordiano: I am not going to argue with that to the extent that I would say that perhaps there are some other reasons that people want to get into this field, but I am not one to know that because I do not run a centre like that, but obviously -- I do not feel that a majority of those operators would stay in the field. I would question that, and that is a reality I suppose.

Mrs. Somers: I think that is something none of us knows really.

Mr. Cordiano: Yes, that is right. It would be speculating, but I would predict that a number of those would leave the field and as result we would be left with fewer spaces in the interim.

Thank you.

Mr. Chairman: Mr. Johnston?

Mr. Johnston: Thank you, Mr. Chairman.

Well, I think what I just heard from the Liberal party's position on this as it develops is of great interest to me and having watched it now for many years, it seems to be that you could not move to the other methodology because the present commercial operators would not tolerate being asked to phase themselves into a non-profit board and the only reason I can presume what is being said from that is that they would want to maintain the profit motive and that this is their bottom line as is being said to you by so many people.

Mr. Cordiano: It is one of the lines.

Mr. Johnston: It seems to me.

Mr. Cordiano: The bottom line....

Mr. Johnston: I love the way you guys just take a vote. I mean, here I am sitting nice, almost quiet and...

Mr. Mitchell: You were not listening to the comments that were made by some of them, quite frankly, and the difficulty they have of even trying to raise money to build the facilities necessary, that they do not-- the Feds do not respond to them very well.

Mr. Chairman: I would ask Mr. Johnston to avoid evoking the responses from the either party. Perhaps you would care to direct the questions to the witness. She has to be away by two o'clock and if you wish to make statements after, I would be happy to hear them.

Mr. Johnston: I gather there is a nervousness even in the chair here.

Mr. Chairman: No, not at all. I'm nervous about Mrs. Somers' flight at two o'clock and that we get her there.

Mr. Johnston: I draw your attention to the standing order in terms of what I am allowed to do and not allowed to do in this process.

Mr. Chairman: I appreciate that. I appreciate that.

Mr. Johnston: Thank you. And you will remember that I am allowed to do this any way I want once I have the floor, unless I abuse that which I have not done as yet and if you do not like it, I suggest to you that you can rule me out of order if you want to try.

Mr. Chairman: You know I would not do that except it evokes responses and we have three voices clamouring for the floor.

Mr. Johnston: I am sure that Hansard will understand that there is only one that they should be writing.

The point I want to make is that if the real problem is as people are saying that the profit basis would come as a bottom line, that this will always be something which they think is problematic because of the nature of the service that we are talking about here, then all you are doing, sir, when you make the comment you are, Mr. Cordiano, about what will happen if you actually force them to convert to community boards, et cetera, is that they will drop out is that you are admitting that that is the case and if you admitting that that is the case, then I ask members of the parties opposite: What kind of service do you think think day care is now?

Surely I thought we got past the notion that one, it was the old babysitting concept that we had back in the 1950s that moved then to social welfarism in terms of providing the poor a means of getting assistance whereas everybody else could pay for it if they wished to have two families in the work force, to now the acceptance of the fact that the majority of the people who require some kind of child care assistance during their time in the work force; and that two, it is beneficial to children to have this in terms of their early childhood education and in terms of preparing them better for the education system and then the life system that they are going to have to move into later on as they come out of the school system.

If you believe it has evolved to that point and you think it has a value of that kind of crucial importance then the matter that we are trying to determine here to the witness is: Is this a program which should be done on a non-profit basis as a matter of universal right and access, or is it something which can be a mixture of profit and non-profit or is it something which should be done on a commercial basis?

I leave it to the witness to involve her in my rant. In your view, what are the linkages that you would make now with day care in terms of its grid status as a service within that framework? We have health care services, some of which are provided at this stage in a totally

not-for-profit basis, others like nursing homes which are provided on a mixed basis but primarily in a for-profit mode. We have things like prosthetic devices finally now becoming part of things that people can accept on a non-profit basis in terms of getting it on an automatic situation, but we have a real mix in social services and we have education where there is a developing debate as to whether or not it should all stay in the public market.

Where do you see day care fitting within that and why; in philosophical terms, why?

Mrs. Somers: I think obviously for my presentation, I see it fitting in the not-for-profit field. It should be a basic social service in the way that education is, in the way the majority of health care is and the reason I feel that is that I do not see anything in the history of social services or education which has really shown that we are able, through the market, to provide the sort of care that we really need or the sort of education that we need.

Secondly, I feel and more probably more importantly and even more important that philosophically this is a most very, very important area of children's education. We fund universities to an enormous extent and yet everything we know in the area of child development tells us that those first four years are the most crucially important and everything we do after that is really putting things together again, or maybe putting the icing on the cake.

But if we can really give those children a good start, a head start, then they are away and yet we are consistently refusing to look at that evidence. It is there in black and white and yet it is being ignored. It has been there since the 1950s and it is just very sort of disappointing to us always to feel that we always have to come cap in hand, we always have to ask, explain why we do not really want it left to the market to provide the services.

I just wish I did not have to be here again. I have been here too often with my particular rant, if you like.

Mr. Johnston: You have been lured into a discussion as others have been of the notion of standards being something which we should be looking at in terms of the notions of quality of care within a profit versus non-profit and it is a legitimate -- I do not use lure pejoratively, except that I am thinking about it as a dangerous trap for us all to get into and into a mind set when we are trying to deal with the philosophical underpinnings of a rationale for why we do something in a profit mode or in a non-profit mode.

And I would ask you -- I mean you have had suggestions we should have a lot more inspectors and you have carried

that nicely I thought in terms of we do not want day care police out there as our means of deciding whether or not the the system is working. But I guess what I want to be clear from you is that, in your view, a philosophical importance of day care as early childhood education and perhaps the most important element of education, is the important principle involved here and not the question as to whether or not we can now come up with standards again which we have already done a couple of times, but new standards that would apply to both profits and non-profits in terms of the administration of day care programming.

And I see a real danger in getting lured into that question. Can we monitor them well enough, the profits in this case, to get away from your concerns about how day care is being dealt with philosophically in terms of whether it should be part of the "education system"?

Mrs. Somers: I do not believe that -- I feel in all government services that the inspection is only one; and even in the area of, for instance, drug regulation which I know something about, it is the companies that have to regulate themselves, then they present their evidence to the government. The government is really only a very small part of it and this is what I am really saying to you about day care centres. We have to regulate them ourselves, we have to have a vision of what we should be doing. We have to do it very well and I just do not believe that the profit motive comes in there and I do not know how often I can say it or how many different ways I can say it, but that is really the philosophical feeling I have about it and, you know, I have seen it work and I think we have a very good example in Ottawa-Carleton of a good system evolving and I would hate to see it turned around.

Mr. Johnston: We have a very difficult task in this committee in terms of trying to make some sense out of past government policy, in terms of what is profit and what is non-profit and why in the various sectors; health and social services. And thank you for coming giving your opinions today on this.

I have just come back from Nicaragua as Ms. Hart is no longer here at the moment, but one of the things that strikes you when you are there is that they deal much more conceptually in terms of where they are going on programs than we do here. We often get caught up too much in the notions of short term expediency, in terms of, in this case, the cost of expanding day care to meet the perceived political needs in the country for some action on day care.

And what I see here, and this is maybe not the kind of thing that we normally speak about in this kind of committee, is that in dealing, trying to make our decision about where day care should fit in all of this, we have to,

yes, look at the historical perspective and what the number of spaces are and all the financial ramifications that there might be there, but we should also be looking at some of the interplay of philosophies here.

And I would suggest to you that my position is that the Democratic philosophy, the notion of participation and control by the people through their own local boards and through their government, is a more important principle when you are dealing with something as basic as the primary education of a child than is the notion of the capitalist notion of profit being an important motivator in our society and that this is not a time to mix those two things and that in some cases we have seen that very clearly especially in public education in the past and I think the challenge for us as a committee at the moment is to go back to first principles and decide what it is we believe day care is and child care is.

And if we believe it is -- as I gather the witness does -- as fundamental as our basic public education system, then we must sacrifice the concept of the profit motive in order to ensure that the Democratic process of full accountability and control by the people over that kind of system is in place and I think that is going to be our challenge, my challenge and others to get through to you during this process that the mix is not possible, developed that we have now, given the evolution of day care and what it needs to be in our society for the future.

Mr. Chairman: Mrs. Somers, could I ask you a question?

Do I understand your position to be that there should be no for-profit day care centres, that they should be phased out over three years?

Mrs. Somers: No. I think my position was that those that wished to continue to work in the present system where they receive government funding should, over a period of three years or whatever would be decided, something fairly short to really make it serious, should get into an approved corporation, become a corporation and set up a board, a parent board or a community board or whatever.

Mr. Chairman: Thank you,

Mrs. Somers: So at the end of that time they would be then eligible for government funds. The others would then be private just in the way the private schools are, it would be dependent on...

Mr. Cordiano: They would not receive any government subsidies?

Mrs. Somers: Unless they were...

Mr. Cordiano: You see the problem I have with that...

Mr. Chairman: Just let me pursue that for a second, Mr. Cordiano. I just want to clarify in my own mind.

So you are not saying that there would not be private day care service but they would not receive any funding from government?

Mrs. Somers: That is right.

Mr. Chairman: Let me just put this scenario to you. Let's say that the private for-profit day care centres developed along the lines of being, because of that, far superior but were very much more costly because there was no government subsidization and a person whose child, felt strongly enough about their child that they wanted this child to have the benefit of this perhaps far superior day care than the not-for-profit, how would you propose that that -- first of all, how would you propose you would get around the question of whether or not that would be a charter breach in that there would be no equality for these children and how would you assist those people in terms of getting to this hypothetical better quality day care?

Mrs. Somers: I would not. I mean, I would regard it exactly the same system that we have for the private schools and it would be a parent choice to make to spend that money in that way and good luck to them if they feel that that is...

Mr. Chairman: But what if they cannot afford it?

Mrs. Somers: There will be enough licensed care, licence subsidized care for them and that is the other side of it.

Mr. Chairman: So what you are doing, and I do not want to intrude on Mr. Cordiano's question, but what you are doing is you are saying it is all right to set up two systems and if one happens to be of a higher quality but costs more that people of society who cannot afford to send their children to that cost more, better -- assuming you had that, and I am not saying that that is the case now, but assuming you had it -- that they should be just denied that right?

Mrs. Somers: But I think that we do that all the time in our society. You know, some of us cannot afford to go to Harvard, other people cannot afford to use expensive private hospitals which maybe very good, I mean, but we know that we have basically good public education, basically good

health care and so I would not feel very uncomfortable but I mean, would you like me to say let's close down every private day care?

I mean that is a very dictatorial, authoritarian thing to say. What we are saying is if there is two systems they will probably have to exist in tandem. My feeling is that many of them will wither away unless they come into the public system because people will not be able to afford the costs but there may well be a few, you know, in the real Rolls Royce day care centres that the rich will use, like Upper Canada College of day care.

Well, I do not have too much of a problem with that and we have lived with it with schools. Why can we not live with it with day care. But we are not saying that the rest of us will not have any day care at all, that there will be all around the corner with the sitter who we pay \$5 a day to who is maybe not looking after our children, because that is what we are saying now.

Mr. Chairman: Yes, but in the long range as Mr. Mitchell said, that is changing. I mean we are seeing presently -- well, in the decision before the Supreme Court of Canada there may very well be some pronouncements that are made out of that judgment which may change that in light of section 15(1) of the Charter.

In any event, you have answered my question.

Mr. Cordiano?

Mr. Cordiano: See the difficulty I have with the notion that we should not have any subsidy for the commercial sector is that we do that already in a number of other sectors, a number of other industries where the government would like to attract more industry and, therefore, would introduce tax deferrals or out and out direct grants for various companies to be attracted and investment to pour into this country.

One would argue also that we have Crown corporations that from time to time run huge deficits and, therefore, we have to put in more money and we are also subsidizing oil companies, that is the Federal Government is, through tax schemes, various tax schemes and we have a non-profit or -- I should qualify that, I should say a profit Crown corporation operating in that sector for stated policy objectives.

See I have a bit of difficulty when you say we should not subsidize the spaces because obviously it is a purchase for service agreement that we are introducing there and we are buying the service from that centre.

Mrs. Somers: But I think, you know, it comes back to the whole philosophical do you believe that this is a business, or do you believe it is a basic human service? And I do not think day care is like oil companies or....

Mr. Cordiano: Well, I could argue that, we do need jobs. I mean, taking it to its logical conclusion, if we are going to argue on philosophical ground, we need jobs and, therefore, you know, if we are going to attract companies where this is the competitive nature of North America where jurisdictions are offering incentives for firms to set up shop in their jurisdictions?

Mr. Johnston: It is being done to encourage kinder care here in Canada?

Mr. Cordiano: I am not saying that. As a philosophical argument -- now, do not extrapolate on that and bring in your own philosophy on this because really you make it a political argument which I am not trying to make, I am trying to make a philosophical distinction here with one side and another.

I happen to believe along with you that certainly it would be an ideal situation that which you described, to have a non-profit operated child care system right across the province, that would be the ideal situation because I think that in the long run if you see it as a public service and if you see, as you have described, the educational need and the development of children, then certainly there is a lot more effort that we would have to put into that, but then along with that we would have to put in greater resources and so how -- again we go back to this question as a practicable matter, how do we get there? How do we establish our educational system? It was done one step at a time.

Mr. Johnston: It was done one step at a time, it sure was not by expanding the commercial sector, however, I remind you.

Mr. Cordiano: Well, I do not think that we want to have a situation in the short term where we really are desperate for spaces and we are just falling behind. that is what we will be doing if we try and destroy that commercial sector right now which we would be doing in effect by only propping up the other side, well then we are destroying one side which provides a certain number of spaces which are more than desperately needed.

I mean, this is a practical situation now that we are talking about, putting aside philosophical issues here, putting aside, you know, being pure in our principles.

Mrs. Somers: Well, you are not going to get it for

nothing. I mean, I suppose that really is what the bottom line is.

Mr. Cordiano: That is right. That is right, and what is the cost?

Mrs. Somers: And so you are going to have to put some money in and however much you go around it and I sat before the Special Committee on Child Care too and they went round and round the issue. I mean, nobody really wants to grasp the nettle and say we have to create a system and in order to do it it is going to cost us money and quite honestly governments find money for things.

I do not really buy your crying poor all the time. I think there are ways of finding money and maybe there are other economies you can make.

Let me just go back to one other point you made, the business of creating jobs. If you really believe in creating jobs, it is a very good way of putting your government money into day care. I mean, it is a very labour intensive thing, so why not do it?

Mr. Cordiano: Well, we could create jobs in the public service, it is very easy to do that.

Mrs. Somers: Yes, but we are not asking you to do that. This is very attractive. They are not going to be jobs in the public service, they are going to be jobs out in the community and they are not going to be civil servants which is what you do not want. It is really not going to be a monolithic society.

Mr. Cordiano: On that argument we could have ten students per classroom in the educational system and create more jobs. I mean what is the ideal situation in approaching that ideal?

Mrs. Somers: You have already got all your children in school so that is not really a problem. You have only got ten per cent of your children in profit day care so you have...

Mr. Cordiano: We have to understand what is reasonably acceptable as quality here and I think that is also and we are far from that, I would agree with you. I am just concerned that we are going to short change ourselves in the interim period and instead of trying to resolve a problem make the situation worse by becoming -- by moving....

Mr. Johnston: If that is your problem, let's just grandfather them, if that is the problem. I have no problem with that. Do you want to do that, grandfather the present

commercials? That would be fine.

Mr. Chairman: Well, I think we have reached the totality of any useful questions that might be asked of you, Mrs. Somers, and we would certainly like to get you back to Ottawa on the two o'clock flight.

Mrs. Somers: Oh, that is all right.

Mr. Chairman: I am sure you have commitments and we thank you very much for coming down here to Toronto to visit with us and before you leave the Clerk will have something to tell you. We have a decision we made earlier she will relate to you.

Mrs. Somers: Thank you.

Mr. Chairman: Thank you very much, and have a safe trip back.

Mrs. Somers: Thank you.

Mr. Chairman: Perhaps you would like to take the snow with you as well?

We stand adjourned until Monday, next Monday.

The committee adjourned at 12:55 p.m.



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